II. NEEDS ASSESSMENT

A. Needs Assessment Process

Needs assessment of the maternal and child health population is a continuous and ongoing process, and critical to program development, to accurate program planning and targeting of services, and to monitoring the effectiveness of interventions. Comprehensive needs assessment requires ongoing sources of information about:

- *Maternal and child risk factors* (age, socioeconomic status, education, previous pregnancy history, physical and emotional stressors, wantedness of pregnancy, and maternal knowledge and behaviors);
- *Access to appropriate health care and capacity of the health care system* (entry into prenatal care, adequacy of prenatal care, access to specialty/tertiary level of care, availability of ancillary or enabling services); and
- *Pregnancy and health outcomes* (fetal deaths, infant morbidity and mortality, maternal morbidity and mortality, low birthweight, prematurity, causes of death);

New York's Title V program employs several methods to identify need for various levels and types of care for pregnant women, mothers, infants and children, including children with special health care needs. Data are available on statewide, countywide and local levels, with ability to do comparisons. Program managers are responsible for incorporating data on changing demographics, and on risk factors and health outcomes for the MCH population into their program plans.

Step 1. Assessing Needs

In this assessment cycle, the needs of the maternal and child health population have been ascertained through:

- Routine surveillance of vital statistics/vital records;
- Census data;
- Registries;
- Provider-generated or program data;
- Hospital discharge data;
- Special studies;
- Community-based assessment data;
- The *Communities Working Together* assessment process;
- The input of families and consumers;
- The input of those who spoke at focus groups, the public hearings or sent testimony; and
- The input of the Maternal and Child Health Services Block Grant Advisory Council.

Many of the data displayed herein are available on the Department's intra-net the Health Information Network or HIN, on the HPN or Health Provider Network, and most on our public website www.health.state.ny.us as a part of the Community Health Data Set. Most are available on the county level, and many on the sub-county or zip code level.

Vital Statistics Data: Historically, birth, death and fetal death certificates have been the main source of information for maternal and child health surveillance. They offer information on birth outcomes, maternal socio-demographic characteristics, prenatal and intrapartal care on an annual basis on the state, county and sub-county level. From these sources, information is generated on different mortality rates, the percentages at various birthweights, the percentages

of prenatal care in each trimester, the adolescent pregnancy rates, fetal losses, live birth-to-pregnancy ratios and maternal mortality.

Census Data: The US Census is a classic and elegant source of data down to the sub-county level. The Department is making full use of data from the 2000 census.

Registries: De-identified aggregated information is also available from the Department's various registries, including the HIV/AIDS, Congenital Malformations, Newborn Screening, Communicable Disease, Tuberculosis, Sexually Transmitted Disease, Cancer, Heavy Metals (lead), Trauma and Immunization Registries.

The State Education Department maintains a registry for each of the licensed professions, and this is a good source of data on physician age, specialty and practice location. This information is useful in assessing access to care in the various areas of the State and predicting or verifying health personnel shortages.

Provider-Generated or Program-Generated Data: Considerable data are generated by programs such as WIC, the Immunization Program, the Family Planning Program, the Childhood Lead Poisoning Prevention Program, the Early Intervention Program, the Newborn Screening Program, the Preventive Dentistry Program, the Children with Special Health Care Needs Program, the Dental Rehabilitation Program, and the Community Health Worker Program. These data are often useful in profiling various segments of the community that are using services, but have the limitation that not all are population-based. Caution must be used in interpreting these data, since they reflect only the characteristics of those who are program-eligible and have actually sought services.

Medicaid Utilization Data has been very useful in the past. As less of Medicaid is fee-for-service and more Medicaid-financed care is delivered under a managed care model, newer systems have been developed and are being refined. These systems provide data to serve as a basis for inference regarding the adequacy and quality of care.

Provider performance reports have been released annually since 1994 through New York's **Quality Assurance Reporting Requirements (QARR)** system. QARR measures many maternal and child health indicators, such as risk-adjusted low birth weight rates, initial access to prenatal care, vaginal birth after cesarean section (VBAC) rates, risk-adjusted primary cesarean section rates, rates for HIV testing of pregnant women, completion of postpartum check-ups, access to facilities for high-risk deliveries, completion of health preventive screenings, childhood immunization rates, and well child visits both in the first 15 months of life and at ages 3, 4, 5, and 6. Adolescent well care visit rates are also calculated, as are screening rates for alcohol, tobacco and substance use. The system also monitors appropriate use of medications for people with asthma, ages 5 through 20.

The **Statewide Perinatal Data System**, now on-line in all regions outside New York City, is able to provide information on the course of prenatal, perinatal and newborn care. There are inpatient, Newborn Intensive Care Units, and outpatient ambulatory care modules. The secure, internet-based system allows real-time access to important perinatal information on an individual, institutional, regional and statewide basis.

The **Integrated Child Health Information System (ICHIS)** is a data warehouse of children's health-related information, linked anonymously and longitudinally across multiple data sources. The primary goal of ICHIS is to serve as a single, primary source of child health data and information that identifies and monitors different child populations, allows identification and follow-up of specific child health areas of need, and enables improved targeting and effective

planning of children's health programs and services. Currently, ICHIS is populated with data from birth certificates, death certificates, SPARCS, congenital malformations registry and vaccine-preventable disease occurrences. ICHIS is currently de-duplicating Immunization Registry information, which will shortly be added. PRAMS, WIC Pediatric Nutrition Surveillance, MA managed care encounters, child blood lead screening tests, lead poisoning case management, newborn metabolic screening and dental surveillance data are all scheduled for addition to ICHIS.

Hospital Discharge Data: Hospital discharge data offer detailed medical information and information about the socio-demographic characteristics of mothers, infants and children who enter and are discharged from New York's hospitals. The **SPARCS** data system, which collects information on every hospital discharge in the State, yields information on length of stay, level of care required (i.e. NICU vs. regular nursery), costs and rates of hospitalization for various morbidities (such as asthma, gastroenteritis, otitis media, head injuries and other conditions). Information is available on how many hospitalizations are drug-related or occur as the result of a motor vehicle crash. As more care is handled on an outpatient basis, information in this system becomes less reflective of the health of the community. As a result, systems are being built for collecting Emergency Room encounter data beginning this year.

Special Studies: The **Pregnancy Risk Assessment Monitoring System** or **PRAMS** collects population-based information on maternal knowledge, attitudes and behaviors, on service access and utilization, and on possible physical and emotional stressors during pregnancy from a sample of women who have recently given birth. Examples of data that are available through PRAMS include: percentage of moms who drank alcohol or smoked during their pregnancies, who experienced physical violence in the year prior to delivery, who were satisfied with the number of prenatal visits, and who breastfed beyond their baby's first week of life. PRAMS also indicates the number of pregnancies that were unintended, that is, not wanted or wanted later. New York initiated PRAMS in 1993 with assistance from the Centers for Disease Control and Prevention. The State's PRAMS grant covers those parts of the state outside New York City. New York City Department of Health has recently initiated PRAMS in the City, which, when completed and combined with data collected by NYSDOH, will provide PRAMS data for the whole State. The State PRAMS staff continue to collaborate with New York City Department of Health.

Each year, the Office of Medicaid Management creates a **prenatal study file**. This is an annual match of birth certificates with Medicaid prenatal care records that supports evaluation of prenatal care and birth outcomes for Medicaid-enrolled women.

The **Youth Risk Behavior Study (YRBS)** collects information on the knowledge, attitudes and behaviors of high school students in the State. This study excluded New York City until 1996, but New York City data is now available. YRBS is conducted every two years by the State Education Department.

On a wider adult population, the **Behavioral Risk Factor Surveillance System (BRFSS)** collects valuable information on behaviors associated with the development of chronic diseases and the use of health resources. Information on these risks is collected nationally by telephone survey using a standardized questionnaire.

BRFSS information is now being made available at the county and regional level. Population-based telephone surveys are conducted in 38 localities comprising the entire state using methods comparable to the Center for Disease Control and Prevention (CDC) methods. A number of the localities are single counties; other counties are grouped together. A total of 630 interviews with adults, aged 18 years and older, will be conducted in each of the 38 localities. The questionnaire includes an 8-minute CORE module that is the same in each locality. In addition, each locality is able to select modules they would like added to the basic survey. A standard 4-minute

questionnaire is also available for counties who do not opt for selecting an individualized set of additional questions. The advantage to selecting the standard module is that those counties will be able to compare responses to other counties that selected the standard questionnaire. The Census Bureau's **Current Population Survey (CPS)** reflects demographics such as age, sex, race and socioeconomic status. These data are available on the state level only. The last available year is 2003.

The Federal Maternal and Child Health Bureau has recently completed a National State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs (SLAITS CSHCN Survey). The Division of Family Health has begun analysis of New York State data.

Local Community Health Assessment Data: Each of the State's 58 local health departments in New York are required to submit a Community Health Assessment to the State Health Department every six years, with updates required every two years. This assessment interprets vital statistics information, local trends, disease rates and special access issues, which the local health departments are then expected to address. Community health assessments are a particularly rich source of data describing unmet needs for direct medical services or for enabling services on a local level.

The Public Health Information Group and the Office of Local Health Services coordinated an intensive review of each county's assessment and provided feedback to local departments. They are also helping local staff to identify their training needs, further advance their local assessment skills, select priorities that provide the greatest opportunities to impact public health in their jurisdiction, and define their plans as a community. Many local departments are developing more comprehensive assessments and plans as a result.

The satellite version of the CDC training program, "Public Health Data: Our silent partner" was televised as a collaboration with the Public Health Information Group, the Office of Local Health Services, the University at Albany School of Public Health, and the New York State Association of County Health Officials. Public Health Information Group staff also provide live training sessions to improve data analysis capacity at the local level.

The *Communities Working Together* Public Participation Process: Communities Working Together served as great model for including communities in the process of setting public health priorities. The Department continues to assist localities in identifying and address local priorities through a collaborative, open, community-based process. Hospitals are now working with local health departments in formulating Community Services Plans required by the State Hospital Code.

Input of Families and Consumers: The Department continues to work to improve parent and consumer input into the design and implementation of maternal and child health and Children with Special Health Care Needs programs. Two years ago, family and consumer forums were conducted in twelve locations with the goal of having families and consumer identify, through their own experiences, parts of the health care system that are not welcoming, supportive or working for them. This year, that process was again repeated, and additional focus groups will be conducted in late Summer and early Fall 2005. The idea is to improve maternal and child health programs through the expressed needs of consumers.

The Family Specialist, the SSDI Coordinator and the Title V Coordinator met with parents and graduates of the "Making the Pieces Fit" training to write a strategic plan for enhanced parent involvement. Parent planners then assisted in formulating the agenda for the forums. The plan was then implemented with assistance from parents, local agency partners and the NYSDOH

regional staff. Parents of children with special health care needs are surveyed annually for their input on implementation of the parent involvement plan.

Through a contractual arrangement with two of our Comprehensive Prenatal/Perinatal Networks, 12 more focus groups were conducted. Downstate, the Northern Manhattan Perinatal Partnership conducted focus groups with Native Americans in Suffolk County, African-American women from Nassau County and Far Rockaway (Queens), Asian women from Lower Manhattan, Middle Eastern families from Brooklyn, Puerto Rican and Mexican women from Nassau County, homeless moms at an American Red Cross shelter, and Caribbean/Dominican women from Northern Manhattan. Upstate, the Mothers and Babies Perinatal Network conducted focus groups with refugees from Bosnia and other Eastern European countries settled in the Mohawk Valley, and with rural, low-income mothers and migrant and seasonal farmworker families from Western New York, as well as pregnant and parenting teens and a group of grandparents raising young children in the Southern Tier area.

Parents also have a major role in the policy and program development in the Early Intervention Program. Early Intervention conducts parent policy development training and the Early Intervention Parent Workgroup addresses a variety of service delivery issues.

Testimony at Public Hearings: Each year the Maternal and Child Health Services Block Grant Advisory Council and the Department of Health sponsor a series of public hearings across the State. This year's locations were Albany, Rochester and New York City. In addition to those who testified in person, written testimony in the form of letters and email notes were also accepted. Requests for copies of the block grant application increase each time a pubic hearing notice is posted.

Input from the Maternal and Child Health Services Block Grant Advisory Council: The New York State Department of Health established the Maternal and Child Health Services Block Grant Advisory Council in 1983, following the enactment of Chapter 884 of the New York State Laws of 1982. The Council serves in an advisory role to the Department regarding the administration of funds under Title V of the Social Security Act. The Council assists the department in determining the program priorities and in soliciting public input for the preparation of annual applications.

By mandate of statute, the Council is composed of twelve individuals, six of whom are appointed by the Governor, three of whom are appointed by the Temporary President of the Senate and three of whom are appointed by the Assembly Speaker. Also by law, members are to include representatives of local government, the not-for-profit sector, and the community. The Council is fully constituted at twelve active members.

The Council members, in their advisory capacity, bring a wealth of experience, information and concern to the table. Advisory Council members carefully consider the testimony offered at public hearing, and often bring new information encountered in their daily professional lives, in formulating their recommendations to the Commissioner and the Governor.

Current members are:

- **Dr. William Grattan, M.D., *Council Chairperson***
  Pediatrician and former Health Commissioner of Albany County
  (Governor's appointment)

- **Richard Aubry, M.D., M.P.H.**
  SUNY Health Science Center, Syracuse, New York

(Senate appointment)

- **Mecca S. Cranley, Ph.D., R.N.**
  SUNY at Buffalo College of Nursing, Buffalo, New York
  (Governor's appointment)

- **Thomas R. Curran, D.D.S.**
  Maxillofacial surgeon and member of Chemung County Board of Health
  (Governor's Appointment)

- **Joan Ellison, M.P.H., R.N.**
  Director of the Livingston County Department of Health, Mt. Morris, New York
  (Governor's appointment)

- **Shirley Gordon**
  Gordon & Gordon Associates, Inc., Albany, New York
  (Senate appointment)

- **Neil Heyman**
  Southern New York Health Association, New York, New York
  (Governor's appointment)

- **Sarah Liebschutz, Ph.D.**
  University of Rochester, Rochester, New York
  (Governor's appointment)

- **Donna O'Hare, M.D.**
  New York, New York
  (Assembly appointment)

- **Christine Saltzberg, Ph.D., R.N.**
  Pittsford, New York
  (Assembly appointment)

- **Joseph S. Sanfilippo**
  Binghamton, New York
  (Assembly appointment)

- **Stanley Skinner**
  Schenectady Municipal Housing Authority, Schenectady, New York
  (Senate appointment)

Step 2. <u>Examining Capacity</u>

To assess system capacity, New York's Title V program, consistent with the Ten Essential Services of Public Health and the CAST-V framework, continually re-evaluates New York's ability to:

a. Assess and monitor maternal and child health status to identify and address problems;
b. Diagnose and investigate problems and hazards affecting women, children and youth;
c. Inform and educate the pubic and families about maternal and child health issues;

d. Mobilize statewide and community partnerships between policy makers, health care providers, families, the general public and others to identify and solve maternal and child health problems;
e. Provide leadership for priority-setting, planning and policy development to support community efforts to assure the health of women, children, youth and families;
f. Promote and enforce legal requirements that protect the health and safety of women, children and youth and ensure public accountability for their well-being;
g. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care;
h. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs;
i. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
j. Support research and demonstration to gain new insights and innovative solutions to maternal and child health-related problems.

Assessing Capacity with regard to Direct Medical Services: Comprehensive assessment of the maternal and child health population's ability to access high quality health care and to determine any gaps in the health care delivery system takes place at both the state and local level. DOH program staff monitor for access issues at the provider level, also.

Statewide, assessment activities utilize vital records to assess access to prenatal care and births by level of facility. SPARCS data, which are data on hospital discharges, are used to assess hospitalizations for ambulatory care sensitive conditions and source of payment at time of delivery. Program data and registries are used to monitor immunization and lead screening rates statewide, access to WIC and family planning services, and linkages to Early Intervention, specialty care and care coordination. QARR outlines access and quality of health care from Medicaid Managed Care, Child Health Plus and commercial Health Maintenance Organization enrollees. The Behavioral Risk Factor Surveillance Survey questions respondents about whether they were unable to consult a physician because of cost. Enrollment in public or private insurance and insurance status can relate directly to access to care, but should be interpreted with caution; enrollment in insurance, including public insurance, does not guarantee access to care.

Information about high-risk populations, health needs and service delivery is best obtained through local county health department, health care providers and the consumers themselves. These are rich sources of information on gaps in local service delivery and the treatment experience of people in need. Key information is also obtained from contractor workplans and consumer focus groups. The new Children with Special Health Care Needs data system and the national SLAITS survey will fill a gap in our knowledge of this population, augmenting what was learned through the Family Voices/Brandeis study.

New York employs multiple strategies to ensure access and availability of primary and preventive maternal and child health services to its population. Strategies include:

- providing low income and disabled New Yorkers with a generous Medicaid, Child Health Plus, Family Health Plus and Family Planning Benefit Program insurance packages;
- providing incentives for small businesses to purchase health insurance for employees;
- ensuring availability of adequate numbers of health care professionals through participation in programs such as the National Health Services Corps, the State Health Services Corps, providing practitioner incentives to practice in underserved areas, and recruitment of under-represented minorities to health professions;

- providing "public goods" such as bad debt and charity allowances and provision for graduate medical education through pools established under the New York Health Care Reform Act;
- providing sufficient regulatory authority to ensure necessary programs are of high quality; ensuring adequate infrastructure at the level of the State Health Department;
- ensuring, by law, linkages between levels of care, such as between Level One birthing hospitals and Level Two and Three hospitals and with Regional Perinatal Centers;
- raising awareness of health services in vulnerable populations through extensive health outreach and health education campaigns;
- providing the Growing Up Healthy Hotline to direct consumers to services;
- providing enabling services such as Medicaid transportation, translation and community health worker assistance;
- assisting providers to become more culturally competent;
- encouraging cross-system collaborations to better meet the human services needs of New Yorkers;
- contracting for the provision of gap-filling direct health services when none are available otherwise;
- providing state local assistance funds to ensure public health capacity at local county health departments; and
- actively monitoring gaps in services and access issues at the community level through local community health assessment.

The shift in recent years from a rate-setting to a free-market environment, and the expansions in Medicaid, managed care, Child Health Plus and Family Health Plus, have enabled some local health departments to concentrate less on providing direct medical services and more on providing population-based services. More and more of the population is receiving care in a managed care environment, and New York is presently moving toward mandatory Medicaid managed care.

Welfare reform has had a noticeable effect on Title V populations. Welfare to work programs are moving mothers into the workplace. The State is working to ensure that they have adequate benefits and safe and healthy child care. New York is working to assist mothers entering into the work place with job training, extended supportive benefits, and expanding capacity and quality in the child care system.

Welfare reform is also changing the way MCH services must be delivered. Providers have had to adapt to the fact that there can no longer be a reliance on daytime clinic visits or home visits. Fewer mothers and infants are at home during the day, and low-income workers may not be able to take days off without losing pay. Services must be delivered during weekend and evening hours, or in convenient settings, like school-based health centers or workplace programs.

The passage of the Family Health Plus Program, modeled on Child Health Plus, is very exciting. This program provides benefits similar to those under Child Health Plus to low income, working adults who are not eligible for regular Medicaid.

Even 100% enrollment in expanded Medicaid or insurance initiatives does not assure that all children and pregnant or parenting women will get access to the care they need. Other factors, such as the maldistribution of providers, shortages in providers that will accept Medicaid clients, large distances to specialty centers, and shortages of culturally-competent, bilingual staff may have a negative effect on access to appropriate direct medical services. When these trends and issues in utilization are noted, Title V programs are expected to then assess appropriate interventions, whether enabling services, population-based approaches or infrastructure-building activities.

Assessing Capacity with regard for Enabling Services: Disease and disability do not affect all segments of society equally. The need for enabling services often becomes apparent when health outcome data are analyzed. Consumers and local providers have taught us that disparities are often the result of the complex interplay between financial, structural and personal issues like socioeconomic conditions, culture, language and education, and are not necessarily due to lack of health care resources. Often, the need for enabling services (transportation, translation, referral and care coordination) become more apparent when communities look for reasons for underutilization of resources and poor health outcomes.

The need for additional enabling services is often gleaned from information from the direct services systems, from disparities in health status, and from consumers themselves. All Title V programs are required to examine barriers to health care in the populations they serve, whether financial, cultural, geographic, institutional or personal, and to institute measures to minimize or eliminate those barriers in collaboration with other stakeholders.

All Title V and Title V-related programs are also required to have extensive linkages and referral networks, thus assuring that care is delivered at the appropriate level of specialty and in the appropriate community or regional setting. Compliance with program linkage requirements are monitored by DOH program managers. The new statewide Perinatal Data System will allow an in-depth examination of referral patterns between community-based providers and differing levels of perinatal care.

Certain populations present unique access issues that make them particularly vulnerable to poor health outcomes. Migrant and seasonal farmworkers and their families are one example. Each year, between 15,000 and 70,000 migrant and seasonal farmworkers come to New York to perform the skilled, manual tasks needed to get New York's crops planted, tended, harvested, processed and prepared for market, or to care for agricultural animals. These workers include men, women and children who have unique difficulties accessing and sustaining contact with the health care system. Health problems often reach very serious levels before care is sought, and the migrant family must often move on before care is completed. Because there is little continuity in their care, and because the work itself can be dangerous and stressful, complications from poorly controlled acute and chronic conditions are very common in this group. In-camp, culturally- and language-appropriate services and assistance with linking to health services, both in their present location and future locations, is imperative to improving their health status. The Migrant Health Program provides just such care, and continually evaluates their capacity to assist the population in sustaining contact with the health care system.

Program data from the Community Health Worker Program show that enhanced outreach, the modeling of care-seeking behavior, and providing a supportive, helping relationship can help low-income, oftentimes overstressed mothers and families to engage and remain engaged with the health care system and to gain better health outcomes for their families.

Assessing Capacity with regard for Population-Based Services: The need for population-based services may surface on a statewide or community level, based on a health need that can be prevented, controlled, or ameliorated, through a public health intervention that is safe, accepted, economical and effective. Examples of factors assessed to determine the need for population-based services are immunization levels, blood lead screening levels, incidence of anemia and overweight, oral health status, injury rates, rates of neural tube defects, or the recognition of a widespread need for certain knowledge. These needs may become known through the analysis of vital statistics, use of registry data, analysis of queries for health information, the administration of population-based Knowledge, Attitude and Behavior (called KAB) studies, focus groups or other types of special studies.

Assessing Capacity with regard for Infrastructure-Building Services: The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to perform adequate needs assessment, to appropriately evaluate public health issues and programs, to develop meaningful policies and standards, to engage their communities, to coordinate existing resources, to ensure quality, and to adequately train the public health workforce.

In late 2001, the New York State Public Health Council appointed a public health infrastructure workgroup and charged it with the task of assessing the public health system infrastructure in New York State. Members of this workgroup included individuals in academics, medicine, public policy, government, private foundations, the business community, and the voluntary sector. In December 2003, the Public Health Council presented a report to the Commissioner titled, ***Strengthening New York's Public Health System for the 21st Century.*** The report reviewed the strengths and needs, as well as made recommendations for improvement around the public health infrastructure around: the public health workforce, public health organizational systems and relationships, public health data and information systems. The Department will be working toward implementing the recommendations during the coming years.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors, our regional offices, other units within the State Health Department and other State and Federal agencies;

- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor workplans;

- Monitoring the ability of our programs, our contractors and county health departments to effectively achieve the desired results;

- Monitoring and auditing the use of available resources, including available technical assistance;

- Monitoring the mainstream health care systems for their ability to respond to cultural and language differences, changing trends and demographics and public health emergencies;

- Annually reassessing our internal controls system for areas of vulnerability; and

- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Step 3. Selecting Priorities

Utilizing annual Needs Assessment, priority setting is conducted as a melding process, combining:

1. the results of the open, public input processes;
2. the use of the many and various data sets available to the Department;
3. the use of program data and provider input to identify trends and issues;
4. infrastructure evaluation;

5. the input of the public and the Maternal and Child Health Services Advisory Council and consumers to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
6. the input of key staff within the Department.

Step 4. <u>Setting targets</u>

New York's State initially developed its state performance measures and performance targets under the pilot of the new application process seven years ago. Measures were picked that best depicted our State's goals for maternal and child health; that is, those that were not already in the core set of Federal Performance Measures. In the 2001 application, new measures were drafted based on the inclusion of some of our measures as Health Status Indicators, based on the new needs assessment, and based on enhanced consumer and Advisory Council input.

Following the five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted in 2002. For the Fiscal Year 2003 application, performance targets were updated based on this improvement cycle, based on parent and consumer input, and based on the more detailed needs assessment process required for that application.

The table that follows summarizes the relationship between New York's priority needs and Federal and State Performance and Outcome Measures.

Priority Area	**Applicable National Performance Measure**	**Applicable State Performance Measures**	**Applicable Outcome Measure**
Access to Care	1 – 18	1, 2, 4, 10	1 – 6, NY
Oral Health	9,15,18	3,9	1
Disparities	8, 11, 15, 17, 18	1, 2, 4, 5, 6	1 – 6, NY
Asthma	---	2	6
Tobacco	---	3, 9	1, 2, 3, 5
Alcohol	---	8	6
Resp. Sexual Activity	8	1, 4	---
Lead Screening	13, 14	10	6
Self-Inflicted Injury	16	7	6
Parent Partnership	2, 3, 4, 5, 6	---	---

Please refer to Form 11 for New York's Performance Targets. Performance targets were set in consideration of present status on the measures, Healthy People 2010 goals and, to ensure that the target set was realistic, trends in achievement over the past few years. In places where New York State had a perfect score, the goal is to remain at that level. The method varied somewhat with the measure.

National Performance Measure (NPM) #1: New York has consistently achieved 100% on newborn metabolic screening, and aspires to continue our success in this area.
National Performance Measure 2 through 6 are new as of last year, taken directly from the SLAITS survey. The first year's data will be used as a baseline.

The goals for the following measures were set based on Healthy People 2010 Objectives for the Nation:

- National Performance Measure #8, the rate of births to teens ages 15 to 17;
- National Performance Measure #16, the rate of suicide deaths among 15 to 19 year olds;
- National Performance Measure #18, relative to first trimester prenatal care;
- State Performance Measure #1, relative to unintended pregnancies;
- State Performance Measure #3, women who smoked while pregnant;
- State Performance Measure #6, infants placed on their backs to sleep;
- State Performance Measure #8, high school students who drank alcohol in the last 30 days;
- Outcome Measure #1, infant mortality;
- Outcome Measure #3, neonatal mortality;
- Outcome Measure #5, perinatal mortality; and
- State Outcome Measure, maternal mortality.

National Performance Measure #9, percent of third grade children who have received protective sealants, was previously NPM #7. Goals were set at a level below the Healthy People Objective, but at a level that is believed to be a realistic endpoint.

The following targets were set based on trends or linear projection of current progress and by what is believed to be a realistic endpoint:

- National Performance Measure #7, immunization levels;
- National Performance Measure #10, deaths due to motor vehicle crashes in children under age 14;
- National Performance Measure #11, percentage of mothers who breastfeed their infants at hospital discharge;
- National Performance Measure #12, percentage of children screened for hearing loss before hospital discharge;
- National Performance Measure #13, percent of children without health insurance;
- National Performance Measure #14, percent of potentially Medicaid-eligible children who receive a service paid by the Medicaid program;
- National Performance Measure #15, percent of very low birthweight infants;
- National Performance Measure #17, percent of very low birthweight infants who were delivered at a facility for high risk deliveries and neonates;
- State Performance Measure #2, hospitalization rates for asthma;
- State Performance Measure #4, teen pregnancy rate;
- State Performance Measure #5, ratio Child Obesity (ages 2-4) Low Income
- State Performance Measure #7, hospitalizations for self-inflicted injuries;
- State Performance Measure #9, high school students who smoked cigarettes in the last month;
- State Performance Measure#10, children screened for blood lead before their second birthday;
- Outcome Measure #2, ratio Black Infant Mortality to White Infant Mortality;
- Outcome Measure #4, postneonatal mortality rate; and
- Outcome Measure #6, child death rate.

Endpoints may be above or below the Healthy People 2010 Objectives. Program staff and Division of Family Health and Center for Community Health administration review accomplishments on Core and State Negotiated Performance Measures, along with other strategic measures, in each application cycle. This information is then used to inform program managers of areas where improvement is or is not occurring at the expected rate and identify strategies for improvement.

Step 5. Identifying Activities

Activities planned for FFY 2005 are included in section IV. New York's annual plan flows from the identification of priority needs, progress on the National and State 5-year performance and outcome measures, consumer and advisory input and the capacity and resources of this agency and its partners. Anticipated program activities will be described by level of the pyramid and by segment of the Title V population--meaning whether the service relates to services for pregnant women, for mothers and infants, for children or specifically for children with special health care needs.

Step 6. Allocating Resources

In each of the last program years, the Maternal and Child Health Service Block Grant Advisory Council has re-affirmed its "Principles and Guidelines for the Use of Block Grant Funds." This document has continued relevance to allocation decisions to ensure maximum benefit from New York's allocation. These guidelines, coupled with the structure for the MCHSBG reflected by the MCH Pyramid, guide their recommendations for reductions/increases in program allocations, and/or redirection of program focus or elimination.

Principles of Allocation of the Maternal and Child Health Block Grant Funds

I. Programs must support functions and be consistent with the purposes of Title V, The Maternal and Child Health Services Block Grant.

II. In general, MCHSBG funds must support needed functions for which adequate funds are not available through other sources. However, availability of these funds should be determined on a case-by-case basis considering criteria established below.

III. MCHSBG funds should be targeted so as to render the greatest public health benefits while maximizing limited resources. Criteria for targeting include:

- identification of populations at greatest risk or need based on geographic, demographic, social, cultural and economic factors;
- mortality and morbidity;
- availability of effective and cost-effective interventions;
- ability to measure program outcomes; and
- inadequate funding from other sources to meet the need.

IV. These funds should be used to augment, not supplant, other funding sources, and when possible, should support demonstration projects and coordination activities that can later be maintained by other funding sources.

V. Block Grant funds should not be used to support basic research.

VI. Block grant funds should be directed toward preventive services as much as possible. When funds must be allocated for personal health care services because of demonstrated need and lack of any other funding sources, preventive services must be incorporated into these services.

VII. Block Grant funds should be allocated in a manner consistent with Federal and State requirements and be consistent with the Public Health Priorities of New York State.

VIII. Block Grant funds should not be used to support established public health services.

Step 7. <u>Monitoring Progress</u>

The Department and the MCHSBG Advisory Council have been monitoring and will continue to carefully monitor MCHSBG-funded programs to assure that block grant resources complement rather than duplicate the direct provision of personal health care services under Medicaid and expanded insurance or eligibility initiatives such as PCAP, Child Health Plus and Family Health Plus. Careful attention has been given to ongoing need, effectiveness and availability of alternative resources, enabling the redirection of resources to bolster core public health functions, improve systems development and support community-based prevention initiatives and safety net services.

Program managers and administrators are responsible for monitoring progress on health and process outcomes related to their programs.

B. Five Year Needs Assessment

1. Conducting the Needs Assessment

The needs assessment cycle was described in Section II A. Stated simply, New York's Title V program determines need through assessment of delivery systems, agency capacity and the health care environment; health status and health outcome data; and information supplied by key informants, namely parents, consumers, program staff, providers and other interested parties. Needs are ranked according to the severity of the problem, the number of people affected, the human and monetary cost to individuals and society, and the years of productive life lost. Our framework for examining need and for designing effective solutions to public health issues was provided in the ***Communities Working Together*** process.

New York State Department of Health also incorporates Healthy People 2010 Objectives for the Nation into virtually all goal setting and programming.

New York's Planning Framework—*Communities Working Together*: In the summer of 1996, the **New York State Public Health Council** undertook an inclusive process to recommend priority areas for public health action for the next ten years. The Council appointed a 19-member **Public Health Priorities Committee** to seek statewide input and to recommend health objectives for the State. More than 1,400 New Yorkers participated in regional forums held in six different locations across New York State, bringing forward the most serious public health issues in their communities, the underlying causes of these problems, and the interventions that could be most effective. The Committee also enabled input from state and local public health professionals and other New York agencies, surveyed other states for their experiences identifying health objectives, and reviewed indicators of New York's current health status compared to the rest of the nation and with the *Healthy People 2000* national objectives.

In formulating the health priorities report, the Committee's overall goals were to focus community attention and stimulate action in those areas that can lead to the most significant improvement in the functional lifespan of all New Yorkers and reduce health disparities among New York residents. The Committee relied heavily on community input received at the regional workshops and was guided by five key principles:

1.) Local communities can have the greatest impact on health by intervening in the **causes of poor health,** rather than focusing on the health problems themselves.
2.) The greatest improvements in health can be achieved in areas where there are **effective interventions that involve the entire community and the individual.**
3.) The priority health areas must address those conditions that result in the **greatest morbidity, mortality, disability and years of productive life lost.**
4.) The priorities should reflect **problems of greatest concern to local communities.**
5.) Progress should be measurable through **specific, quantifiable, and practical objectives.**

The Committee, in their final report ***Communities Working Together for a Healthier New York,*** identified 12 priority areas, most of which had a maternal and child health component, and addressed these priorities as "opportunities for action": (Readers will note the similarity of the Committee's choice of "opportunities" with the ***Healthy People 2010*** "Leading Health Indicators," which came out later.)

- Access to and Delivery of Health Care
- Education
- Healthy Births
- Mental Health
- Nutrition
- Physical Activity
- Safe and Healthy Work Environment
- Responsible Sexual Activity
- Substance Abuse: Alcohol and other Drugs
- Tobacco Use
- Unintentional Injuries
- Violent and Abusive Behavior

The report asked communities to collaborate in addressing the underlying causes of poor health, stressing the need for a commitment from all New Yorkers and from all sectors of our society. While the regulatory role of government, for instance in ensuring safe water or surveillance and control of infectious diseases, was not listed as a priority area, the report cautioned that government must continue to meet its responsibilities for essential public health infrastructure. The report underscored the need for assessment, policy development and assurance functions to be maintained to meet the objectives of the report.

The outgrowth of this community exercise has been a convergence of planning and implementation activities across the State. In 1997, the Maternal and Child Health Services and Preventive Services Block Grant Advisory Councils reviewed the report and affirmed their priorities in light of the ***Communities Working Together*** report. Local health units were given grants to convene community planning groups to begin the local implementation process. Key local stakeholders were invited in 1997 to attend a statewide workshop entitled ***Focusing the Message: Mobilizing Communities for Public Health Priorities***. The workshop showcased effective collaborative projects from across the State, presented key information about collaborative approaches, and gave participants the opportunity to improve their team-building and meeting skills.

In 1998, stakeholders attended a second conference, which included a recognition ceremony celebrating the progress made by local communities in their quest for a healthier New York. This exciting event allowed communities to share their successes and learn from the success of others. Sixty-two collaborations were described in a publication of the New York State Community Health Partnership and the Milbank Foundation entitled, ***Partners in Community Health: Working Together for a Healthier New York 1998,*** which was distributed to over 2,700 agencies and individuals.

As a state health agency, we continue to use the principles and goals enumerated in ***Communities Working Together*** as a guiding framework to approach health issues. Last year, achievement data were updated to reflect progress in the first five years of ***Communities Working Together***. Progress reports were prepared and shared with the Public Health Council, local communities and DOH programs.

More specifically, the charts that follow summarize important data used to establish the need for services by population group and level of the MCH Pyramid.

Direct Medical Care – Preventive and Primary Care for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • dental services; • prenatal care; • mental health services; • health insurance; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Unwanted, mistimed pregnancy rates Adolescent pregnancy rates/birth rates Low birth weight rates Perinatal and infant mortality rates Early entry into prenatal care rates/late and no entry rates Kotelchuk Index Disparities in birth outcomes between population groups Maternal mortality rates/study Behavior Risk Factor Survey results on access to care Percentages of uninsured children and families Immunization data Rates of hospitalization for asthma and otitis media Rates for perinatal transmission of HIV and Hepatitis B Family and consumer input MCHSBG Advisory Council input Local community health assessments Program data, including data from Medicaid, Child Health Plus, CSHCN, the Community-Based Adolescent Pregnancy Prevention Program, the Children with Special Health Care Needs program, the Family Planning Program, the Preventive Dentistry Program, the Dental Rehabilitation Program, the Migrant Health Program, the American Indian Health Program, and School-Based Health Centers
Healthy births	Low birth weight rates and very low birth weight rates Adolescent pregnancy and birth rates Perinatal and infant mortality rates Rates for early entry into prenatal care Disparities in birth outcomes between population groups PRAMS data Family and consumer input MCHSBG Advisory Council input Local community health assessments Early intervention program and CSHCN program data Use of appropriate level of birth facility Cost of hospitalization for NICU in human suffering and dollars Medicaid and Managed Care data Maternal morbidity and mortality data Congenital anomaly registry data

Direct Medical Care – Preventive and Primary Care Services for Children, Ages 1 through 21	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • dental services; • mental health services; • health insurance; • counseling on risk-taking behaviors; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Immunization Rates – by age, location, payment source, insurance status, etc Rates of dental caries – by age and economic level Rates for placement of dental sealants Lead screening data Adolescent pregnancy rates High rates of use for tobacco, alcohol and other drugs Rates for suicide attempts and suicides Family/suicide survivors' input Family and consumer focus groups MCHSBG Advisory Council input Local community health assessments Rates of hospitalization for self-inflicted injuries Rates of unintentional injuries STD and HIV rates Health disparities information Rates of hospitalizations for ambulatory care sensitive conditions Rates of risk-taking behaviors MA data/EPSDT Child Health Plus coverage rates

Direct Medical Care – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Improved access to comprehensive, continuous, age- and sex-appropriate primary and preventive care and specialty level care, including access to: • medical homes; • referrals to appropriate specialty services and higher levels of care; • needed durable medical equipment and supplies; • supportive services, like respite; and • family involvement.	Use all of data sources mentioned above under "Children," plus: Parent and consumer input Public hearings MCHSBG Advisory Council input Family Voices/Brandeis study Children with Special Health Care Needs Program data Dental Rehabilitation Program data Early Intervention Program data Local community health assessments MA data/Child Health Plus data SLAITS

Enabling Services – Preventive and Primary Services for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Early and improved access to prenatal care and other primary and preventive care through: • enhanced and sustained outreach; • transportation; • translation services; • role modeling appropriate care seeking behaviors; • parenting support; • health guidance; • insurance programs; • assistance with locating and accessing services; and • referral and support services.	Medicaid utilization and QARR data Rates of early and late/no entry into prenatal care Kotelchuk Index PRAMS data Program reports (migrant health, adolescent programs, school health) Rates of uninsured Data on source of payment for obstetrical deliveries Family and consumer input MCHSBG Advisory Council input "Growing Up Healthy" Hotline and other MCH-related hotline calls The number of hotline callers who inquire about eligibility based on immigration status Local community health assessments MA/PCAP data

Enabling Services – Preventive and Primary Care Services for Children, Ages 1 through 21	
Need Identified	**Supporting Data/Documentation**
Same as above.	Same as above. Substitute Hospitalizations for Ambulatory Care Sensitive Conditions for prenatal care measures.

Enabling Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Same as above. Additional need identified: Assistance with care coordination and with vendors for home care/medical equipment.	Use all of data sources mentioned above under "Children," plus: SLAITS Family Voices/Brandeis study Parent and consumer input MCHSBG Advisory Council input Early Intervention and Children with Special Health Care Needs data

Population-Based Services – Primary and Preventive Care for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
Healthy births	Rates of early entry into prenatal care Rates of late and no prenatal care Kotelchuk Index Perinatal Hepatitis B and HIV transmission rates Rates of prenatal HIV counseling and testing Rates of low and very low birth weight Mortality rates: infants, perinatal, postneonatal Breast feeding data Maternal mortality rates PRAMS data PCAP/MOMS data Advisory Council and Public Hearings/consumer input

Population-Based Services – Primary and Preventive Care for Children, Ages 1 - 21	
Need Identified	**Supporting Data/Documentation**
Improved oral health and better access to preventive oral health services	NYS Oral Health Survey Percentages of water supplies that are fluoridated Rates of dental caries Data on dental underserved areas Rate of Medicaid children who receive a dental preventive service (includes sealants and dental exams) Data on lack of dental insurance and high out-of-pocket expense Family and Consumer Input Public Hearings/consumer input Advisory Council input
Improved access, on a population-wide basis, to comprehensive, continuous, family-focused, community-based, age- and sex-appropriate primary and preventive care, including access to: • family planning information and services; • medical homes; • mental health services; • health insurance; • counseling on risk-taking behaviors; • statewide availability of services; • referral to appropriate levels of care; and • prevention of secondary disability.	Rates of uninsured Youth Risk Behavior Survey data on use of alcohol, drugs and tobacco. Rates of intentional injuries/suicides/suicide attempts Rates of teen pregnancies and births SPARCS data on hospitalizations for ambulatory sensitive conditions including data on asthma Immunization levels and occurrences of vaccine-preventable diseases STD and HIV morbidity data Local community health assessment data Program data (lead poisoning, family planning, school health, etc.) Family and consumer input Public Hearings/consumer input MCHSBG Advisory Council input

Completion of high school and compulsory health education	Data on drop out rates and associated socio-economic consequences Level of maternal education data Rates of high school non-completion among teen moms and others
Mental health	Rates for teen suicides, attempted suicides, intentional injuries Youth Behavioral Risk Survey data on use of substances, mental health Program data (School-Based Health Centers, ACT for Youth)
Responsible sexual behavior	Youth Behavioral Risk Survey data on use of contraception, students forced to have sex when it wasn't wanted, age at initiation Unplanned and adolescent pregnancies and births Rates of induced terminations of pregnancies Morbidity data: STD, HIV Program data (Family Planning, Community-Based Adolescent Pregnancy, Abstinence Education, School Health)
Nutrition and physical activity	Nutrition surveillance studies WIC program data YRBS
Reduced use of tobacco, alcohol and other drugs	Youth Behavioral Risk Survey Rates of injuries where drugs and alcohol are involved
Reduction of violence/intentional injuries	Youth Behavioral Risk Survey SPARCS data on hospitalizations, ER use for injuries Calls to the child abuse and neglect hotline Rape Crisis Program data

Population-Based Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Need for comprehensive, continuous, family-centered, community-based system of care for the full population of children with special health care needs, including: • readily accessible information about the location and availability of services; and • access to and insurance for accessing appropriate levels of care and appropriate specialty services.	Use all of data sources mentioned above under "Children," plus: SLAITS Family Voices/Brandeis study Parent and Consumer input Public Hearings input MCHSBG Advisory Council input

Infrastructure Services – All Populations	
Need Identified	**Supporting Data/Documentation**
Continued need for a strong and vibrant public health infrastructure that supports maternal and child health services in New York State	There is a continued need for the infrastructure to support: • Assessment of problems and conditions that affect the MCH population; • Ability to identify and bring resources to bear on priority health issues; • Coalition-building and collaboration skills; • Availability and access to necessary technical assistance; • Appropriate numbers, types and distribution of MCH/public health personnel; • Statewide accessibility, availability and acceptability of MCH services at all levels of care; • Form effective linkages between/across systems of care; and • Assurance of quality through assessment and monitoring of local health departments, providers and contractors, law and regulations.
The need for infrastructure that supports access an array of affordable, high-quality, comprehensive, continuous, culturally-competent, linguistically-appropriate services for all MCH populations	Uninsured data and program utilization data GIS locators for facilities and practitioners/underserved areas Health personnel data and registries Locations of providers, comprehensiveness of provider networks Linkages between primary, secondary and tertiary levels of care Appropriate monitoring and regulation Special populations data

Infrastructure Services – Primary and Preventive Services for Pregnant Women, Mothers and Infants	
Need Identified	**Supporting Data/Documentation**
An infrastructure that promotes healthier births: • affordability and access to insurance for prenatal and intrapartal care; • appropriate array of services/ locations; • regionalized system of perinatal care; • family planning education and services that promote appropriate spacing of children; • content of care that includes risk assessment and patient education; and • linkages to nutrition and other support services.	Data on uninsured Vital Statistics and SPARCS data on payment for source deliveries Locations of providers and facilities Linkage agreements between levels of care Rates of unintended and teen pregnancies and births QARR and MA data Percentages of high-risk infants born at tertiary level facilities PRAMS data Program data (Family Planning, Community Health Worker, PCAP and MOMS Programs) Rates of low and very low birth weight Mortality rates Infant Mortality Community Review Panel recommendations Public Hearing, Consumer and MCHSBG Advisory Council input Monitoring and regulatory data

Infrastructure Services – Primary and Preventive Services for Children, Ages 1- 21	
Need Identified	**Supporting Data/Documentation**
Need for infrastructure that supports comprehensive child health and school health and wellness in order to promote: • access to insurance; • access to a full array of screening and treatment services for medical, dental and mental health issues; • responsible sexual behavior; • reduced use of tobacco, alcohol and other drugs; • reduction in unintentional injuries; and • reduction of violent behaviors.	Appropriate assessment capacity Ability to design and implement effective strategies Ability to form statewide and community-level coalitions Insurance/uninsured data Teen pregnancy and birth rates Morbidity and mortality data Utilization data Program data ATUPA enforcement activities Presence or absence of health education services SPARCS data on injuries Youth Behavioral Risk Survey data

Infrastructure Services – Children with Special Health Care Needs	
Need Identified	**Supporting Data/Documentation**
Need for infrastructure that supports: • better assessment of the needs of children with special health care needs and their families; • family-centered care/enhanced family participation in care; • easy access to necessary services; • compassionate, coordinated delivery of care.	Use all of data sources mentioned above under "Children," plus: SLAITS Family Voices/Brandeis survey data Family and consumer input MCHSBG Advisory Council input Public hearing testimony Children with Special Health Care Needs and Early Intervention Program data Medicaid and managed care data Monitoring data

2. Needs Assessment Partnership Building and Collaboration

Communities Working Together sets the stage for other collaborations, as well. Here are just a few of the collaboratives that work with NYSDOH on needs assessment:

Touchstones/KWIC: NYS Touchstones, with the Council on Children and Families in the lead, began as a collaborative of 13 NYS agencies that fund programs and services for children and families. Touchstones is a set of measurable goals and objectives as well as health, education and well-being indicators that reflect the status of children and families in relation to those goals and objectives. The Council produces the Touchstones/KIDS COUNT Data Book annually. The KWIC, Kids Well-being Indicators Clearinghouse, makes vital youth statistical information more timely, accessible and usable to communities in a user-friendly format. The Clearinghouse is available on the website http://www.nyskwic.org/ .

Youth Development Team: The Youth Development Team was an outgrowth of the Partners for Children initiative, created in 1995, as a collaboration of New York State agencies (health, education, mental health, public assistance) and private sector organizations, including the NYS United Teachers, the Schuyler Center for Analysis and Advocacy, United Way of NYS, the NYS School Boards Association, the NYS Association of County Health Officials, the Association of NYS Youth Bureaus, and the NYS Association of Counties. The team brings issues and priorities to the table that might benefit from multi-disciplinary or cross-system state-local action for achieving positive outcomes for youth and families. The group issued a report covering a consensus-constructed, core set of youth development outcome indicators.

Integrated County Planning (ICP) Collaborative: The New York State Office of Children and Family Services (OCFS) developed this strategy to demonstrate an inclusive, integrated county-level planning process focused on improving outcomes for all children, youth, families and adults. Partners include OCFS, the State Health Department, the Office of Mental Health, the State Education Department, the Council on Children and Families and the Office of Alcoholism and Substance Abuse Services. Demonstration counties developed cross systems databases with demographic indicators, survey data and information about existing services. They also developed procedures for collaborative grant applications, common allocation decision making across funding streams and agencies, and common contract management protocols.

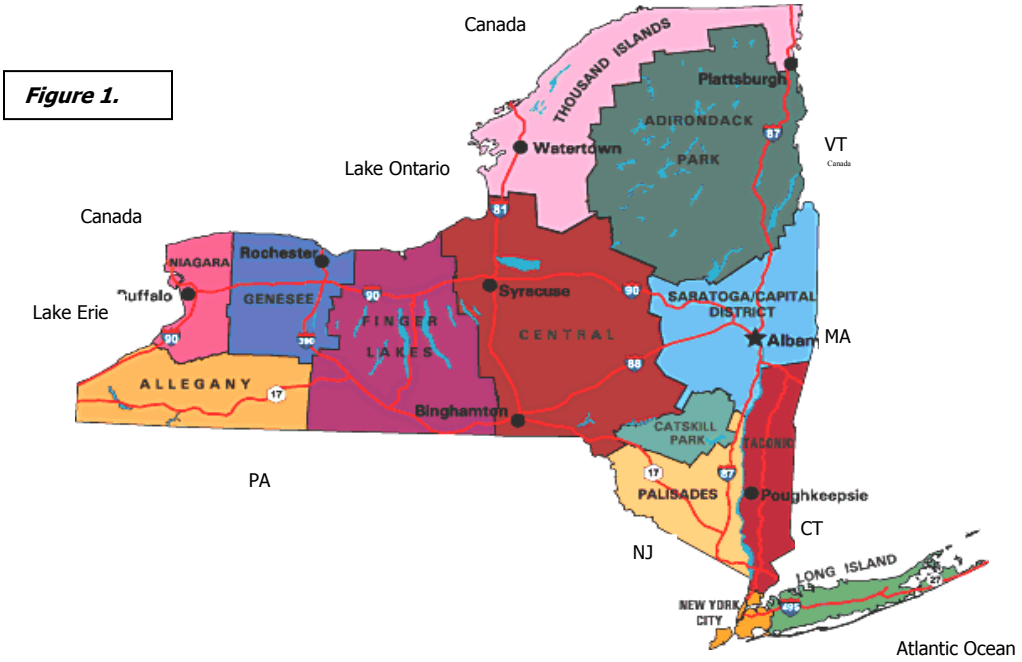
Overall, needs assessment and health planning are the shared responsibility of every program within DOH and their local counterparts, which is successful because:

- *As a State Health Department, we have entered into a partnership with consumers and families, with local health agencies and local communities, and with other State agencies.* These partnerships help Title V to identify the need for additional information and act on those needs.
- *We are united in a common vision for New York and the health of New Yorkers*. Thanks to the ***Communities Working Together*** process, multiple collaborations and partnerships and to the Department's legislative and administrative initiatives, localities are playing a larger role in identifying local needs, designing programs to effectively address local need, and evaluating local results.
- *Title V is supporting this process through the dedication of needed resources*. Support and training are provided to local agencies and partners in their needs/capacity assessment and planning efforts.

Assessment of Needs of the Maternal and Child Health Population

Geography: New York State has a total area of 54,471 miles. That includes a landmass of 47,832 square miles and inland water covering 7,247 miles. Bordered to the north and west by Canada and the Great Lakes of Ontario and Erie, to the south and west by Pennsylvania and New Jersey, to the east by Vermont, Massachusetts and Connecticut, and to the southwest by the Atlantic Ocean, the geography of New York is both vast and diverse. Our borders hold 8,000 lakes, nine major rivers, four mountain ranges (the Adirondacks, the Catskills, the Taconics and the Shawangunks), hundreds of small, rolling valleys, fertile glacial plains, awe-inspiring gorges and waterfalls, quaint rural villages, and one of the most vibrant metropolitan areas in the world. (See *Figure 1*.)

Figure 1.



New York's diverse geography can also present interesting public health challenges. While the Finger Lakes and our mountain ranges are among our most beautiful natural resources, these attributes can also impede transportation and delay access to health care. Its location southeast of the Great Lakes ensures temperate upstate summers, but it can also, especially for the Tug Hill plateau region, mean sudden and heavy "lake effect" snowstorms in the winter. And because New York's natural resources attract tourists year-round with recreational activities like boating and skiing, some areas experience a striking seasonal demand on health services, especially in the areas of emergency medical services and public health. Ellis Island, our various ports of entry, and the Statue of Liberty have historically been beacons to newcomers and are well-known entry points for many new New Yorkers and new Americans from around the world.

Population: New York State is notable for the great diversity of both its geography and its people. According to the 2000 US Census, New York State is home to almost 19 million people (18,976,457). New York is now the third most populous state, behind California and Texas. Seven percent of the US population lives in New York. New York City contains 42% of the State's population with over 8 million people (8,008,276).

New York's population is aging. The median age in the State has increased from 10.3 years in 1970, to 32.0 years in 1980, to 33.8 years in 1990, to 35.9 years in 2000. This represents an

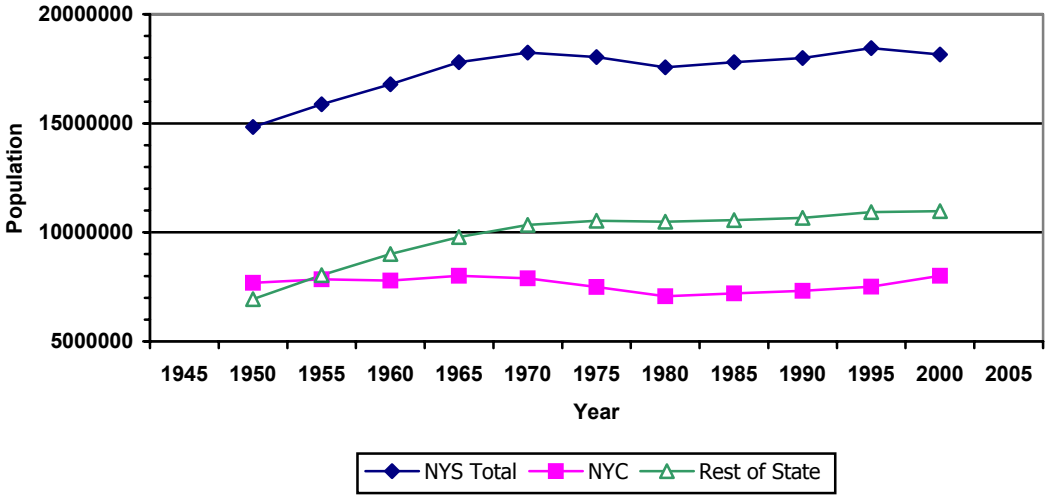
aging of the "Baby Boomers" born between 1946 and 1964, as well as a longer survival rate for the elderly. The expectations for length of life for New York State residents has increased, from 75.2 years for those born in 1991 to 78.1 years for those born in 2000.

Population Growth: According to the 2003 Census projections, 19,190,115 people live in New York State. Population trends indicate that, after a slight downward trend in the late 70's and early 80's, New York's population rose, and then leveled off. (See *Table 1* and *Figure 2*.) New York was the second most populous state until the late 1990's, when it's population growth slowed to less than 1%.

Table 1. **Population of New York State, 1950-2003**
Source: US Census Bureau

Year	New York State	New York City	Rest of State
1950	14,830,192	7,891,957	6,938,235
1960	16,782,304	7,781,984	9,000,320
1970	18,241,584	7,895,563	10,346,021
1980	17,558,165	7,071,639	10,486,526
1985	17,795,916	7,232,980	10,562,936
1990	17,990,455	7,322,564	10,667,891
1995	18,439,500	7,510,600	10,928,900
1996	18,506,400	7,542,500	10,963,900
1997	18,571,800	7,575,000	10,996,800
1998	18,637,800	7,609,200	11,028,600
1999	18,705,695	7,643,800	11,061,900
2000	18,976,457	8,008,278	10,968,179
2001	19,074,843	8,055,166	11,019,677
2002	19,157,532	8,084,316	11,073,216
2003	19,190,115	8,085,742	11,104,373

Figure 2. *Population of New York State 1950-2000*
Source: *US Census Bureau*



Population Density: Population density often determines the number and types of health services that an area can support. The US Census shows that in 2000 there were 401.9 persons per square mile in New York State, compared to 79.6 persons per square mile in the US, but population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state, and New Yorkers are more likely to live in urban areas than residents of other states.

New York County (Manhattan) has the highest population density at 52,808 persons per square mile, while Hamilton County in the Adirondack Mountain Range has the lowest density, with only 3 people per square mile. New York City comprises over 40% of New York State's population, and the counties immediately north of New York City (Orange and Westchester Counties) and Long Island (Nassau and Suffolk Counties) comprise an additional 21% of the state's population. Other population centers are Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County) and Albany (Albany County).

Many areas of New York are rural. Twenty-six percent of New Yorkers live in rural areas, compared to 36% nationwide. According to the New York State Senate Commission on Rural Resources, there are 44 rural counties out of the 62 in New York State that are home to approximately four million rural residents.

Households and Families: In 2000, there were 7,056,860 households in New York State. The average household size was 2.61 people. A family household, by Census definition, has at least two family members related by blood, marriage or adoption, one of which is the householder. The average family size in New York State was 3.22 in 2000. Families made up 65.7% of the households in New York in 2000. This figure includes married couple families (46.6%), female householders (14.7%), and male householders (4.4%). Non-family households made up 34.3% of all the households in New York State. The majority of the non-family households were people living alone. Households containing children under the age of 18 numbered 2,466,483 or 35.0%, and households with adults 65 and older numbered 1,767,452 or 25.0%.

Women of Childbearing Age: The population of women of childbearing age has been decreasing since 1990. In 2000, it is estimated there were 4,220,848 females between the ages of 15 and 44 in New York State. A total of 623,800 females were between the ages of 15 and 19. An additional 618,407 females were between the ages of 10 and 14.

Children: Of New York's 2003 population, 4.5 million (23.6%) were under age 18. The number of children under the age of 20 in 2003 was just over 5 million (5.046,370), broken down by age groups as shown in *Table 2.* Approximately 41% of these children (2,111,183) live in New York City.

Table 2. **Child Population in NYS 1998-2003**
Source: US Census Bureau

Age in Years	Number in 1990	Number in 1999*	Number in 2000	Number in 2002**	Number in 2003**
<1	1,255,764	241,692	1,239,417	256,954	250,062
1-4		996,028		971,190	964,990
5-9	1,178,006	1,367,101	1,351,857	1,269,659	1,224,847
10-14	1,140,177	1,339,242	1,332,433	1,349,522	1,327,017
15-19	1,230,127	1,218,320	1,287,544	1,279,332	1,279,454
Total Birth-20	4,804,074	5,162,383	5,211,251	5,125,657	5,046,370
Total in NYC	1,888,075	2,073,827	2,153,450	2,122,939	2,111,183

*Estimates based on the 1990 Census.
**Bureau of Census projections.

The U.S. Census Bureau estimates that the number of children ages 4 and under is growing in New York City by an estimated 4.6% from 2000 to 2003. Statewide, however, there was a net loss of 1.9%, as the number of individuals of childbearing age decreased in other areas of the state. Demographers attribute the growth in the youngest age groups to the influx of immigrant families in New York City, many of whom are of childbearing age. The Census Bureau estimated that Manhattan had a 20% gain in this age group, the Bronx had a 4.8% increase, Brooklyn a 2.3% increase, and Queens showed a 1.1% increase. Upstate rural counties lost the greatest number of infants and toddlers under age 5: Greene and Schoharie Counties lost 14% each, while Orleans County lost 13%.

Race and Ethnicity: New York's population reflects diverse race and ethnicity; we are more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. New York ranks second of all states in non-citizen immigrants, with 2.2 million non-citizen residents in 1996. Almost 90% of New York's non-citizen immigrants live in New York City.

Between 1990 and 1998, there had been small shifts in the ethnic composition of New York's population, with the population of New York City being more racially and ethnically diverse than the rest of the State. The 1999 New York State population under age 24 was 72% white, 22% African American, and 18% Latino. Approximately 6% were identified as Asian/Pacific Islander.

In 2000 the Census, in an effort to reflect the growing diversity in the US, gave respondents the option of selecting one or more race categories to indicate their racial identities. Because of this change, data from the 2000 Census cannot be compared to earlier censuses. The six single race categories (White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, and Some Other Race) and the two or More Races category are exclusive categories. The majority of New Yorkers (96.9%) reported only one race; 3.1% identified themselves as being of more than one race.

According to the 2000 U.S. Census, the largest group (67.9%) reported White alone, while Black or African American alone represented 15.9 percent of New Yorkers. 7.1% reported being Some Other Race. 5.5% stated they were Asian alone, and 0.4% reported they were American Indian or Alaska Native. Native Hawaiian or Other Pacific Islander accounted for only 0.05% of those reporting.

Hispanics accounted for the majority of the Some Other Race category. Of New York State residents who selected Some Other Race, 94.4 percent identified themselves as Hispanic. Hispanics represent 15.1% of New York State's total population. In New York City, 27% indicated they were Hispanic. Four out of 10 Hispanics did not identify themselves with one of the five specific race alone categories or two or more races category. Of those New Yorkers identifying themselves as Hispanic, 44.2 said they were Some Other Race.

About 70% of African Americans and 75% of Hispanics/Latinos in the State reside in New York City. Among New York City residents, 44.7% reported their race as White alone, 26.6% reported Black or African American alone, 9.8 percent reported Asian alone, and 14.4 percent reported being Some Other Race. About 27% of New York City's population identifies themselves as Hispanic/Latino.

Several counties outside of New York City have significant Hispanic/Latino population, as well. In Rockland, Nassau, Orange, Suffolk, Sullivan and Westchester Counties, Hispanics/Latinos make up at least 9% of the population.

Population growth as a percentage of total population grew between 1990 and 2000 by 29.5% for Hispanics and 9.5% for non-Hispanic Blacks. The Asian population surged by 56.1% to over one million (1,035,926).

Census figures for Native Americans in New York may represent a serious undercount. New York is home to the *Haudenosaunee* or the "People of the Longhouse." These members of the Iroquois League, which was formed centuries ago, formed their confederacy to advance "peace, civil authority, righteousness, and the Great Law." Many traditional members of their nations (the Mohawks, Keepers of the Eastern Door; the Senecas, Keepers of the Western Door; the Onondagas, known as the Firekeepers; the Oneidas; the Cayugas; and the Tuscaroras) do not participate in the US Census. This produces an undercount in US Census data on New York for these important groups.

Form 12 in the Appendix of this document contains a racial and ethnic breakdown for all births.

Table 3.
New York State Population Breakdowns by Race
Source: 2000 US Census

Race Categories	New York Population		New York Hispanic Population			
	Number	% of Total Population	Number	% of Total Population	% of Total Hispanics	% of Race Category
One Race	18,386,275	96.9	2,643,517	13.9	92.2	14.4
▪ White	12,893,689	67.9	1,132,708	6.0	39.5	8.8
▪ Black or African American	3,014,385	15.9	201,762	1.1	7.0	6.7
▪ American Indian/ Alaska Native	82,461	0.4	29,962	0.2	1.0	36.3
▪ Asian	1,044,976	5.5	9,050	0.0	0.3	0.9
▪ Native Hawaiian/ Other Pacific Islander	8,818	0.0	3,588	0.0	0.1	40.7
▪ Some Other Race	1,341,946	7.1	1,266,447	6.7	44.2	94.4
Two or More Races	590,182	3.1	224,066	1.2	7.8	38.0
TOTAL	18,976,457	100.0	2,867,583	15.1	100.0	15.1

A great number of New Yorkers (3,747,874, according to the Census) are foreign born. The largest group of the foreign born are from Latin America (1,818,773). Asians are the second largest group of immigrants (929,297), and Europeans the third (823,899). African immigrants (102,772), other North Americans (67,249) and Oceanians (5,884) follow in descending order.

Languages: In addition to our great cultural diversity, there is also great diversity in languages spoken in New York. Of the estimated 17,144,924 New Yorkers over age 5, an estimated 12,440,299 speak only English at home, while 4,704,625 speak a language other than English. 2,092,875 speak English less than "very well." About 2,360,792 New Yorkers speak Spanish at home. The New York State Education Department found that, of the 3.34 million students attending school in New York, 7.6% were identified as having limited proficiency in English.

Immigration: New York has always served as a major gateway for immigration, and as an entry point for many new New Yorkers and new Americans. Unfortunately, data on immigrants, especially undocumented immigrants, is very scant, and does not break down immigrant populations by maternal and child health categories. The reliability of the data is uncertain, at best.

In April 1998, the Urban Institute published a report with the support of multiple private foundations entitled, "Immigrants in New York: Their Legal Status, Incomes and Taxes." The

report provided demographic and economic information on legal immigrants living in New York State, but it also addressed multiple, significant shortcomings in existing data for immigrants and the fiscal impact of immigration. The report focused on four areas: the size of the legal immigrant population; the characteristics of legal and undocumented populations; the incomes and taxes paid by immigrant populations; and the economic adaptation of immigrants and their descendants. The report gives separate population estimates for naturalized citizens, legal non-immigrants (such as diplomats and foreign students), and undocumented aliens residing in New York State. Estimates are derived from the Immigration and Naturalization Service (INS), the Office of Refugee Resettlement (ORR), and the Bureau of Census. The study estimated:

- New York had a foreign-born population of 3.4 million in 1995, just prior to the initiation of welfare reform. This number represents 17.7% of the State's population, or about one in six people. Only California has a higher percentage (25.1%) of foreign-born residents. The national average for the foreign-born is approximately 9.3%.
- The majority of the foreign-born in New York are here legally (84%).
- About 16% or 540,000 of the State's immigrants are undocumented. Undocumented people represent a smaller percentage of the State's immigrant population than any other major immigrant state, except New Jersey. Nevertheless, New York (with 540,000) is estimated to have the third highest number of illegal immigrants living in the state, behind California (2 million) and Texas (700,000).
- There are approximately one million legal permanent resident aliens and over a million naturalized citizens in New York. These two groups compose about 77% of New York's immigrants and about 15% of the State's total population.
- New York has more naturalized citizens than the country as a whole, probably because more of New York's immigrants come from countries that tend to naturalize and more are long-term immigrants, who are also more likely to naturalize.
- New York has approximately 200,000 refugees, representing 5.9% of the foreign-born population. Most refugees in New York are from the former Soviet Union, while refugees from Southeast Asia dominate in the rest of the country.
- New York's immigrant population is very diverse, with no particular region or country having clear dominance.
- Of the estimated 3.4 million immigrants in New York:
    - About 915,000 or ~27% come from the Caribbean;
    - About 864,000 or ~25% come from Europe;
    - About 665,000 or ~20% come from South or East Asia;
    - About 411,00 or ~12% are from South America;
    - About 171,000 or ~5% are from Central America;
    - About 105,000 or ~3% were from the Middle East;
    - About 45,000 (~1.3%) are from Mexico;
    - About 31,000 (~0.9%) are from Canada;
    - About 26,000 (~0.8%) are from Africa; and
    - About 121,000 (~3.5%) are from other or unknown jurisdictions.
    - The largest single country of birth is the Dominican Republic, with about 395,000 or ~12%;
    - About 229,000 or~7% are from China;
    - About 195,000 or ~6% are from Jamaica; and
    - About 182,000 or ~5% are from the former Soviet Union.
- There is thought to be greater diversity among the undocumented foreign-born than among those here legally. Only New Jersey is thought to have similar diversity in the foreign-born population.
- About half (46.5%) of households headed by legal immigrants and over a third (37.3%) of the households headed by undocumented immigrants contain one or more US natives. Babies born in this country are defined as natives and citizens.

- The incomes of natives and immigrants differ substantially by their status. Based on 1995 income and tax data, the study found:
  - The average native's annual income was $18,100.
  - The average income of the legally present foreign-born was very comparable at $18,000.
  - The average household income for legally present foreign-born individuals ($38,000) is lower than that for households headed by natives ($49,300).
  - Of those that are here in New York legally, naturalized citizens have the highest per capital income ($23,900), surpassing that of natives ($18,100), and far surpassing that of refugees ($8,300).
  - Among New York State residents outside of New York City, legal foreign-born residents were found to have higher incomes than natives, regardless of the measure used. For example, legal immigrants had per capital income of $23,900, compared to $19,100 for natives.
  - The average income for undocumented aliens was found to be substantially lower than for those foreign-born who were legally present, $12,100 vs. $18,000.

Education: According to our State Education Department, in Fall 2002, approximately 3.32 million students were enrolled in New York's public and nonpublic schools. Almost 15% of the States children attend nonpublic schools. 6.3% of all students were identified as limited English proficient, and 11.8% were identified as students with disabilities. Funding for education in New York is provided 42.7% by the State, 52.7% by the local school district, 4.6% by the Federal government. In 1999-2000, state revenue to schools was $30.63 billion.

Breakdowns by race for enrollment by type of school are reflected in Table 4.

Table 4. **Statistics for Public and Nonpublic Schools**
Enrollment by Race by Type of School, Fall 2002
Source: NYS Education Department

Category	Enrollment					
	Total	% White	% Black	% Hispanic	% American Indian/ Alaskan Native	% Asian and Pacific Islander
Public						
New York City	1,030,008	15.0%	38.2%	38.2%	0.4%	12.4%
Large City Districts	122,908	24.7	52.0	20.2	0.8	2.3
Districts Excluding the Big 5	1,659,361	81.3	8.5	6.9	0.4	2.9
BOCES	19873	77.8	13.9	6.2	0.6	1.5
Total Public	2,842,728	54.5	19.9	18.9	0.4	6.3
Total Nonpublic	484,152	68.1	15.3	11.9	0.2	4.5
Total State	3,326,880	56.5	19.2	17.8	0.4	6.1

With a rank of 1 being the best and 51 being the worst, New York ranks third in the US for per pupil expenditure, reflecting the high priority of education in New York (1997-1998 data). The National Center for Education Statistics reports per pupil expenditure in New York was $9,146 in 1999-2000, and averaged $6,585 in the US as a whole. Eighty percent of reading classes have no more than twenty pupils, above the national average of 78%. In the 1999-2000 school year, there were 13.6 pupils per teacher in New York's public schools (per the NYS Education Department), compared to 16.2 pupils per teacher in the US (per the National Center for Education Statistics). There were 14.4 pupils per teacher in New York City schools. According to the US Department of Education, the high school completion rate for people aged 25 and over in March 2000 was 82.5% in New York, compared with the national average of 84.0%. The completion rate for males is higher than for females, 84% compared to 81.3%. 28.7% of New

Yorkers have completed a baccalaureate degree, compared to 26% in the US as a whole. 77% of all NYS public school graduates in the Class of 2000 went on to college, while 59% of New York City Class of 2000 graduates went on to college. The mean SAT I composite score for the Class of 2000 was 1000 in New York, 12 points higher than the mean of the Class of 1993.

Despite the heavy emphasis put on secondary and post-secondary education in our State, there is still concern for the small percentage of students that do not complete high school. The most recent national data from the U.S. Census Bureau shows high school dropouts are about three times more likely to slip into poverty from one year to the next as those who have finished high school. New York is making progress. The New York State Education Department reports that the 2002-2003 dropout rate was 4.6%. On average, large urban districts had higher dropout rates than other districts: the dropout rate for New York City was 8.2%; 7.6% in other large city districts; and 2.2% in the school districts outside the "Big 5" urban districts. In that same school year, 4.4% of students were suspended from school one or more times, and 1.9 % left their secondary schools to attend a GED-preparatory program. The National Center for Education Statistics reported in 1990 that 10.1 % of New Yorkers aged 16-19 were not enrolled in school and had not graduated from high school. This was slightly lower than the national percentage of 11.2%. The New York rate is now at 9%, which is also the national average. Within the State, the percentages varied from 5.2 % in Nassau County to 18.0 % in the Bronx.

Census data indicate that of the 910,676 youth ages 16 to 19 in the State, 77,241 or 8.5% are not enrolled in school and not a high school graduate. Of those, 48,449, or 5.3% of the youth in that age group, are not in the labor force. New York is actively pursuing a Youth Development focus that emphasizes workforce development through the Partners for Children Youth Development/Workforce Development Workgroup and the National Governors' Association (NGA) Youth Policy Network Grant.

Internet access is becoming increasingly more important in education and in accessing information that people can use in their everyday lives. As the use of the Internet becomes more widespread, those without access are at a growing disadvantage. In New York State, between 55 and 58% of the population over three years of age had access to the internet according to an October 2003 Current Population Survey.

Educational Attainment of Mothers: Lack of education is widely recognized as a factor in health, determining how and where people live and the quality of their lives. Low educational attainment influences occupational choices, income and quality of family life. Lack of maternal education is linked with higher utilization of health services, taking fewer precautions in safeguarding their child's health, and with higher infant mortality.

In New York State, 19.0% of women giving birth in 2003 had less than a high school education. Among African American and Hispanic women, the percentage is even higher (25.5% and 40.1%, respectively).

Mothers in New York City were nearly twice as likely as mothers in the rest of the state (23.3% vs. 15.1%) not to have completed high school. The number of mothers without a high school diploma in the Bronx and Brooklyn alone was nearly equal to the number of mothers in the rest of the state outside New York City. Women giving birth in the Bronx in New York City and in Yates County in Upstate New York were least likely to have graduated from high school, with graduation rates of 66% and 63%, respectively. On the other hand, mothers from Putnam and Saratoga Counties had the highest high school completion rates, at 96% and 92% completion, respectively.

Employment and Per Capita Income: According to the New York State Department of Labor Publication, Welfare New York, New York's private sector job count increased by 8,300, or 0.1 percent, to 7,024,200 (seasonally adjusted) in April 2005. This is the eighth consecutive month of private sector job growth. Since the beginning of New York's economic recovery in August 2003, the state has added 116,800 private sector jobs. New York State's unemployment rate, after seasonal adjustment, was 4.9 percent in April 2005, up from 4.6 in March. This is the fourth consecutive month the state's unemployment rate was lower than the nation's rate, which was unchanged at 5.2 percent in April. The last time New York's rate was lower than the nations for four consecutive months was December 1990.

In New York City, since April 2004, the number of jobs has increased by 37,100 or 1.1 percent and the number of private sector jobs has increased by 41,400 or 1.4 percent. The area's unemployment rate was 5.4 percent in April 2005, compared with 5.3 in March and 7.1 in April 2004. The unemployment rate in NYS excluding NYC was 4.3 percent in April 2005, down from 5.1 in April of 2004.

Educational and health services added the most nonfarm jobs over the April 2004-April 2005 period, gaining 26,800 jobs. The sector's gain was centered in health care and social assistance (+19,100). Employment also increased in leisure and hospitality; trade, transportation and utilities; professional and business services; financial activities; other services; construction; government information and natural resources and mining. The only declining industry was manufacturing.

The service sector is the largest employer in the State; employing approximately 45.7% of the employed New Yorkers ages 16 and over, according to Census figures. Retail is the second largest group of employers, employing approximately 10.6%. Manufacturing is a close third, employing about 10.2% of employed New Yorkers ages 16 and above.

Agriculture is a major seasonal and year-round employer in New York. According to the New York State Department of Agriculture and Markets, approximately 39,000 farms covering 7.8 million acres in New York produce and sell about $3.02 billion in agricultural products annually. Livestock, dairy and poultry farming account for about 60% of agricultural sales, while vegetable, fruit, greenhouse and nursery crops are also major contributors to the agricultural economy. The USDA lists New York as the third leading state for milk cows and production of apples and grapes, and rates New York fourth for production of sweet corn and strawberries.

The US Bureau of Economic Analysis reports that residents of New York have a higher-than-average per capita income (total personal income divided by the mid-year population), $36,574 compared to $31,632 nationwide in 2003. But according to the Current Population Survey, the 2002-2003 two year average median household income for New York State, at $42,858, was slightly lower than the US figure of $43,340 for the same time period.

Poverty: Trends, based on the US Bureau of the Census's Current Population Survey have shown a reduction in New York's population below the Federal Poverty Level (FPL), from 18.4% in 1993 to 14.1% in 1999. The 2000 Census figure of 14.6% is higher than the national average of 12.4%. About 17% of New Yorkers had incomes below 125% of poverty in 2000; by 2001, this rate had gone up slightly to 18.8%. In 2003, 14.3% of New Yorkers were below poverty and 18.8% were below 125% of poverty.

Poverty is highly associated with poor health outcomes, especially for women and children. About 11.9% of all New York State families, versus 10% in the US as a whole, lived at or below the Federal poverty level in 2003. Poverty is most common in families headed by single females, and single-female headed households with children under age 5 are more likely than other

families to be living below poverty. This is true regardless of race or ethnicity. Given this, New York continues its commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs. According to the 2004 Current Population Survey, during 2003, 38.1% of the people in female-headed households with children lived below poverty in the state. 46.1% were below 125% of the poverty level, similar to rates in 1999 and 2000, but down from 58% in 1998.

In 2003, 41.3% of all obstetrical deliveries were Medicaid or self-pay. In 2002, 43.6% of all deliveries were Medicaid or self-pay.

New York's child poverty rate shown an improving trend but is still slightly higher than the country as a whole (19.9% vs. 17.6% nationally in 2003). In 2000, 873,000 children between the ages of birth and 18 years lived in households with incomes below the Federal Poverty Level (FPL). This represented 19.0% of all children in this age group. In 2001, the number has fallen to 871,000, 19.6% of the children in this age group. In 2002, the number of children below poverty was 942,000 or 20.5% of the child population. In 2003, 899,000 or 19.9% children lived below poverty. In 2000, 24% of all children birth to age 18 in the State lived in families where the income was below 125% of poverty. In 2001, 25.8% of New York's children, age's birth to age 18, live in families with income below 125% of the Federal Poverty Level. In 2002, the rate was 25.8%, and in 2003 the rate was 25.0%.

In 2000, New York's child poverty rate was at its lowest level in 21 years, largely because the State had increased employment among its most economically needy families. According to the US Bureau of the Census, employment for the State's most vulnerable families rose sharply after implementation of welfare reform in 1995. There was a concurrent 28% decline in the rate of child poverty, from 26.4% in 1994 to 20% in 2001. According to the NYS Office of Temporary and Disability Assistance, reductions in the number of families on Public Assistance were accompanied by a rise in employment among the disadvantaged and a reduction in both teen pregnancies and out-of-wedlock births. In addition, Census data indicates that the upward trend in single mother families and the downward trend in married couple families have abated.

Child poverty is more than twice as common in New York City as it is in the rest of the state, where 44% of the children live in poverty. The Bronx, where half the children are poor, holds the highest child poverty rate in the State. These data underscore New York's continued commitment to employment for parents, and to supportive programs such as the Prenatal Care Assistance Program, Child Health Plus, Children's Medicaid, Family Health Plus, WIC and the Child and Adult Care Feeding Program.

In comparing poverty levels among age groups, the 2001 Current Population Survey found that there is a general decrease in poverty, as individuals grow older. In 2000, the percent of those living in households earning less than 100% of the poverty level were: 19.2% for children birth to age 9, 18.2% for 10 to 19 year-olds, 14.1% for 20 to 29 year olds, 11.6% for 30-39 year olds, and 10.7% for those over 50.

Income Disparities: The Center for Budget and Policy reported that despite a tight labor market, and strong economic growth in recent years, income disparities in New York and most other states grew significantly during the 1990s, and the trend continued into this decade. This is thought due primarily to wage disparities. Factors contributing to wage inequity include the decline of manufacturing jobs, the expansion of low-wage service jobs, globalization and the lowered real value of the minimum wage. Families at the lower end of the wage scale are less likely to afford health or dental insurance, and have less flexibility for out-of-pocket medical or dental expenses.

Access to Primary Care: According to the New York State Behavioral Risk Surveillance Survey, 13.7% of those surveyed in 2004 did not see a doctor when they needed to because of cost. This figure was up from 8.8% in 2000. Among African Americans and Hispanics, 18.6% and 19.0%, respectively, indicated cost prevented them from seeing a doctor. These figures were up from 13.3% and 14.2% in 2000.

More New Yorkers are establishing a medical home under a managed care plan. In 1998, 29.1% of New Yorkers enrolled in the Medicaid program received their care through enrollment in managed care. In the first quarter of this year, about 41% or 901,867 of the 2,187,397 Medicaid-eligible people in the State received their care through a managed care plan. Percentages are higher for the State outside New York City when compared to New York City rates: 49% compared to 37%.

Access to Dental Care: Those who are most vulnerable to dental disease are those of low income, those with less education, those who do not have access to preventive dental care, and those with special health care needs or chronic conditions.

Half of all New Yorkers have an insurance plan to cover oral health services. Even with dental insurance, there tend to be higher out-of-pocket expenses associated with dental care. Dental insurance plans tend to be difficult to purchase and, even when available, cover a limited number of procedures. Fortunately, New York provides a comprehensive package of coverage for those enrolled in Medicaid, Child Health Plus and Family Health Plus.

Even the comprehensive coverage New York offers under public and private dental insurance is not enough to guarantee access. Other factors, such as the geographic location, transportation, the availability and distribution of dentists and pediatric dental specialists, and parent and patient knowledge and attitudes play a significant role in access to dental care, especially for the poor. According to the Behavioral Risk Factor Surveillance Study, in 2004, 71.8% of New York State respondents indicated that they had seen a dentist in the last year.

Health Insurance: The proportion of children between birth and 17 years of age that are uninsured declined between 2002 and 2003 to 9.4 percent. Although the rate of uninsured increased in 2002, it had declined for four years in a row prior to 2002. Historically, the percentage had been steadily increasing since 1990, with the exception of 1995, when it dropped to 9.4%. The rate of uninsured in the general population (15.1%) is down slightly from the 2001 rate of 15.5%, and the 2002 rate of 15.9%. The percentage of children insured by public insurance increased from 30.1% in 2002 to 32.1% in 2003. *(See table below.)*

Percentages of Children Insured by Type of Insurance and Uninsured
Source: Current Population Survey, 1990, 1994-2003

Type of Insurance	1990	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Public											
Birth - 17	21.2%	25.7%	28.8%	29.1%	26.3%	27.4%	28.4%	28.1%	30.3%	30.1%	32.1%
Total Population	23.3%	26.7%	27.6%	27.0%	26.8%	26.7%	25.7%	26.4%	27.8%	27.5%	29.0%
Private*											
Birth – 17	69.2%	60.2%	59.3%	55.7%	58.2%	58.7%	60.1%	61.4%	60.4%	60.0%	58.5%
Total Population	64.4%	57.3%	57.2%	55.9%	55.9%	56.0%	57.9%	58.4%	56.7%	56.7%	55.5%
Uninsured											
Birth – 17	9.5%	14.1%	11.9%	15.1%	15.5%	13.8%	11.5%	10.5%	9.3%	9.9%	9.4%
Total Population	12.3%	16.0%	15.2%	17.0%	17.5%	17.2%	16.4%	15.2%.	15.5%	15.9%	15.1%

*Private included military-related insurance

To address concerns for the 9.4% of New York's children who are uninsured, the Department and local partners are working diligently to find and enroll the children who are Medicaid- and Child Health Plus-eligible and their families who may be Family Health Plus-eligible. Office of Medicaid data showed 87.5% of Medicaid-eligible children were enrolled in 2001, up from 1999 & 2000, when 84.7% and 83.1%, respectively, of eligible children were enrolled. The birth to age four groups and the 15- to 19-year-olds were enrolled at the lowest rates, while the 5- to 9-year-olds and 10- to 14-year-olds were enrolled at higher rates. Facilitated enrollment projects are helping to reach unenrolled children and enroll them in either Medicaid or Child Health Plus.

The Urban Health Institute reported in June 2004 on the National Survey of America's Families. They reported, based on 2002 figures, that among the uninsured, 27.5% had incomes below the Federal Poverty Level (FPL), 21.2% had incomes between 100 and 200% of the FPL, 11.1% had incomes between 200 and 399% of the FPL, and 5.3% of the uninsured had incomes 300% or higher than the FPL. People living in metropolitan areas were slightly more likely to be uninsured than those in non-metropolitan areas (2.1% as opposed to 10.5%). Being uninsured was more common among foreign-born individuals (26.1%) as compared to U.S. born (8.4%). The uninsured were more likely to rate their current health status as fair or poor (23.6%) than excellent, very good, or good (10.3%). 12.8% of the uninsured reported having a limiting disability.

The Children's Defense Fund in August 2000 rated New York as fourth in the nation for insuring uninsured children and doing an excellent job of implementing Child Health Plus. New York enrolled the greatest number of children in their state child health insurance plan, but also was the only state in the top ten that had a decrease in Medicaid enrollment (probably due to a decrease in child poverty), which kept New York from a higher ranking. Governor Pataki commented on the ranking, stating, "No one can match our success in enrolling children in Child Health Plus. Today, more than 550,000 children are getting regular check-ups and immunizations, as well as speech, vision and hearing services, thanks to Child Health Plus. While we are proud of the fact that we've boosted enrollment from 90,000 to more than a half-million today, we won't rest until every child in New York has this opportunity to get the healthy start to life they need – and deserve."

In January 2001, the New York Forum for Child Health announced that the decline in Medicaid enrollment for children had paused. For the first time since July of 1995, when they first began tracking, the downward trend in enrollment reversed. The average Medicaid enrollment for children birth to age 20 in the first five months of 2000 was 1,316,212, compared to the average enrollment in 1999 of 1,313,892. New York City continued to have higher Medicaid enrollment rates or smaller reductions than the rest of the State.

According to the Current Population Survey, the number of uninsured children under the age of 18 in New York State declined from 551,000 in 1999 to 486,000 in 2000, and 425,000 in 2001. In 2003, it was 432,000.

The State of New York has made a huge commitment to public support of health and social welfare services for state residents under Medicaid and other public insurance programs. Additionally, New York has had a Bad Debt And Charity Care Pool for a number of years to cross-subsidize hospitals that bear higher rates of uncompensated care from those with fewer non-paying users. People in need are not turned away from New York's hospitals for inability to pay for services.

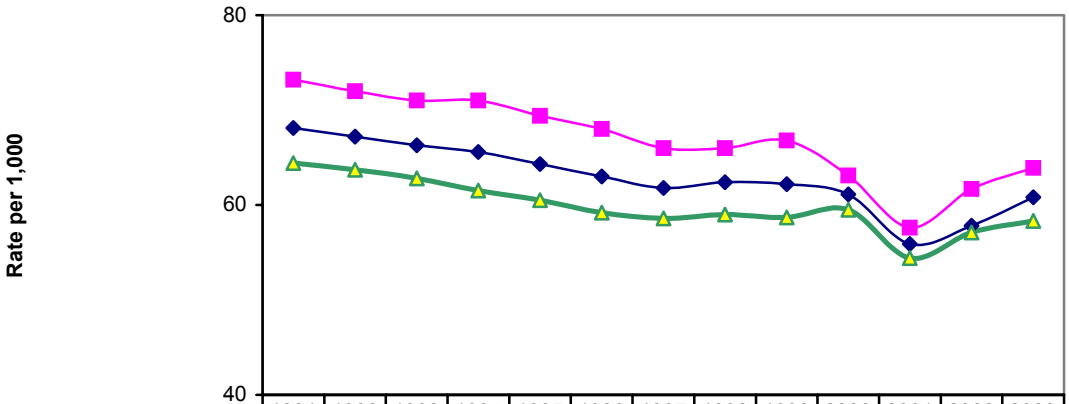
Expanded Medicaid Eligibility for Immigrants: In New York, qualified immigrants formerly subject to the five year ban on Medicaid eligibility and immigrants who are Permanently Residing in the United States Under Color of Law (PRUCOL) may be eligible for Medicaid, Family Health Plus and Child Health Plus A, so long as they meet all financial eligibility and other rules to be eligible for benefits under these programs. Immigrants who are determined to be class members may also be eligible for reimbursement of payment of doctors' and other health care provider bills for care and services received on or after September 12, 1997 and August 5, 2004.

Overall Health: According to the United Health Foundation, the American Public Health Association and the Partnership for Prevention, which regularly assess the overall healthiness of the nation, New York ranked 31st in 2004, which was the same ranking achieved in 2003. Health care spending per capita was $92, with 5.1% of health care dollars spent on public health.

A. Pregnant Women, Mothers and Infants

Birth Rates: After declining from 2000-2001, the birth rates increased slightly again from 2002 to 2003 to 60.8% per 1000 females aged 15 to 44 years. New York City rates (at 63.9 per 1,000) were higher than rates for the rest of the State (58.3 per 1,000). This is an increase from 2002 when the rate was 61.7 per 1,000 in New York City and 57.1 per 1000 females in the rest of the State.

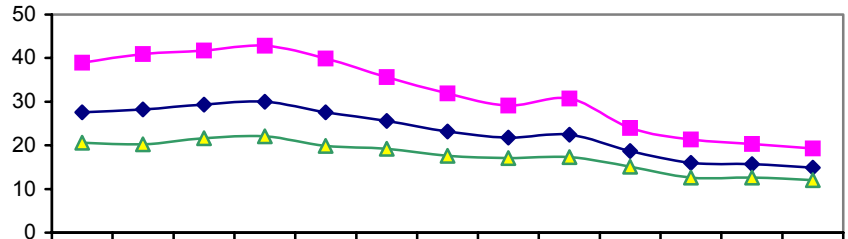
Figure 3. **Births per 1,000 Females Ages 15 - 44**
New York State by Region 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	68.1	67.2	66.3	65.6	64.3	63	61.8	62.4	62.2	61.1	55.9	57.8	60.8
New York City	73.2	72	71	71	69.4	68	66	66	66.8	63.1	57.6	61.7	63.9
Rest of State	64.4	63.7	62.8	61.5	60.5	59.2	58.6	59	58.7	59.5	54.4	57.1	58.3

Adolescent Birth Rates: Birth rates decreased for the 4th year in a row in the 15- to 17-year old group; the 2003 rate was 14.9. The rate has decreased about 20% from 2000 to 2003. Both New York City and Rest of State rates have been declining. The New York City rate, at 19.3 per 1,000, is higher than the Rest of State rate, which was 12.0 per 1,000 young women between the ages of 15 and 17.

Figure 4. **Births per 1,000 Females Ages 15 - 17**
New York State by Region 1991 - 2003

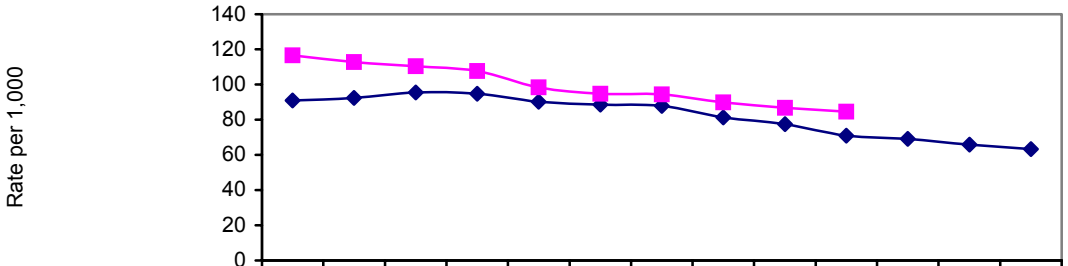


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	27.6	28.2	29.3	30	27.6	25.6	23.2	21.8	22.4	18.7	16	15.7	14.9
New York City	38.9	40.9	41.7	42.8	39.9	35.6	31.9	29.1	30.7	24	21.3	20.3	19.3
Rest of State	20.6	20.2	21.6	22.1	19.9	19.2	17.6	17.1	17.3	15.1	12.6	12.6	12

Adolescent Pregnancy Rates: We know that adolescent pregnancy is highly correlated with lack of educational attainment and lasting disadvantage in earning power and economic potential. Teens are less likely to eat correctly, gain sufficient weight during pregnancy, or get early, continuous prenatal care. Teen moms are at greater risk than women over age 20 for pregnancy complications like premature labor, anemia and high blood pressure. The risks are even greater for teens that are under 15 years of age.

Although New York's adolescent pregnancy rate is lower than the national average, New York is still working hard to decrease pregnancies in this age group. Since 1993 the pregnancy rate for girls aged 15-19 has been decreasing; the 2003 rate of 63.3 per 1,000 is 34% lower than the 1993 high of 95.4/1000.

Figure 5. **Teen Pregnancy Rates per 1,000 Women Ages 15 - 19**
New York and United States 1991 - 2003

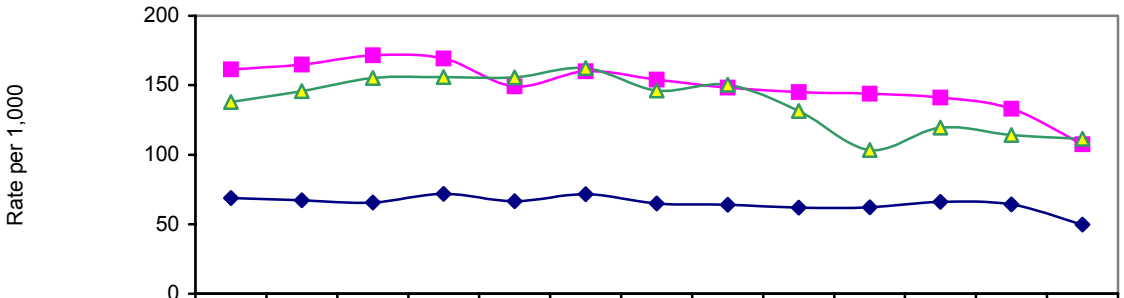


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	91	92.3	95.4	94.7	90.1	88.5	87.8	81.3	77.5	71	69.1	65.8	63.3
United States	116.5	112.8	110.4	107.7	98.3	94.8	94.3	89.8	86.7	84.5	DNA	DNA	DNA

DNA = Data not available.

Among African American in this age group, the rates are double the rates for of White teens. Teen pregnancy rates declined between 2001 and 2002 among African American, White and Hispanic teens. In 2003, due to a change in reporting of population data by race/ethnicity, the rates are not comparable to past years. The change caused an increase in the white and black populations. (Reporting of Numerator data was unchanged)

Figure 6. **Pregnancy Rate per 1,000 Women Ages 15 - 19**
New York State Residents by Race 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	68.7	67.3	65.5	71.7	66.5	71.6	64.9	64	61.8	62.2	66.1	64.1	49.7
Black	161.3	164.8	171.5	169.2	149.1	160	154	148.3	145	143.8	141	133.1	107.4
Hispanic	137.9	145.7	155.1	155.9	155.6	162.2	146.2	150.3	131.5	103.3	119.4	114.1	111.3

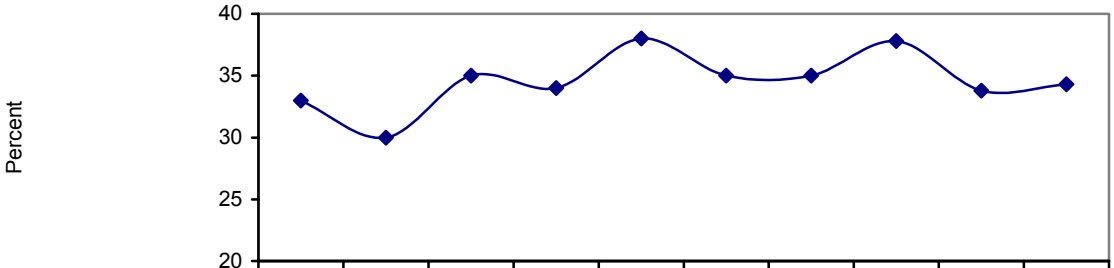
Unintended Pregnancy: In 2002, over one third of new mothers responding to the PRAMS survey indicated that their pregnancy was unwanted or mistimed (34.3%). This rate is an improvement over the 1999 rate of 35.1% and the 2000 rate of 37.8%. It is slightly higher than the 2001 rate of 33.8%.

Groups at highest risk for unintended pregnancy in 2002 were women under the age of 20 (82.2%); women who were not married (61.9%); African American women (60.2%); women on Medicaid (57.2%); and women with less than a high school education (51.9%). Sixty five percent of women reported that they wanted their pregnancy either when it occurred (43.8%), or earlier (21.2%).

Table 5. **Responses to Question on Intendedness of Pregnancy**
PRAMS Survey 1998 to 2002

Response:	1999	2000	2001	2002
Total reporting pregnancy was unwanted or mistimed	35.1%	37.8%	33.8%	34.2%
Of those that were:				
Under age 20	82.3%	75.9%	77.3%	82.2%
Unmarried	68.0%	67.9%	60.0%	61.9%
African American	55.3%	64.4%	56.6%	60.2%
On Medicaid	61.7%	57.2%	56.3%	57.2%
Less than a high school education	57.2%	48.9%	57.1%	51.9%
Total reporting pregnancy was wanted when it occurred	42.0%	44.5%	41.6%	43.8%
Total reporting pregnancy was wanted earlier	22.0%	17.7%	21.6%	21.2%

Figure 7. **Women Whose Pregnancy Was Unintended**
New York State Excluding New York City 1993 - 2002
Source: PRAMS Survey

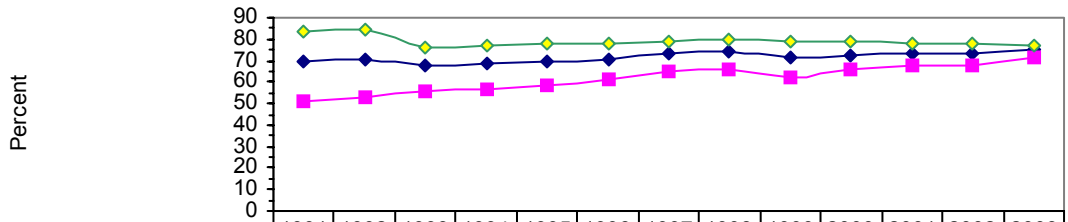


	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
%Unintended	33	30	35	34	38	35	35	37.8	33.8	34.3

Prenatal Care: In 2003 74.7 percent of women giving birth in New York State received early prenatal care. This was an improvement over the 2001 and 2002 rates of 73.0 percent; the 2000 rate of 72.8 percent. Between 1998 and 1999 the percent actually declined slightly. This was partially due to New York City Department of Health changing their method of accounting for "unknowns" recorded for "entry to prenatal care." Prior to this decline, there had been improvement in rates of women receiving prenatal care in the first trimester of pregnancy.

Since 1994, the percent of New York women accessing early prenatal care had increased 8.2% to 73.8% in 1998. Much of that improvement occurred among New York City residents where the percent increased from 56.8% in 1994 to 65.9% in 1998. Although the New York City rate slipped to 62.4% in 1999 the 2000 rate was up to 66%. In 2001 and 2002 the NYC rate reached 67.7%. The rate improved to 71.9% in 2003. In the rest of the State, the rate went from 76.7% in 1994 to 79.7% in 1998. Rest of State rates dropped slightly in 1999 and 2000 to 78.5%. In 2001 and 2002 the rate declined further to 77.7 percent. The 2003 rate was 77.4%. These rates are still below the Healthy People 2010 goal of 90%.

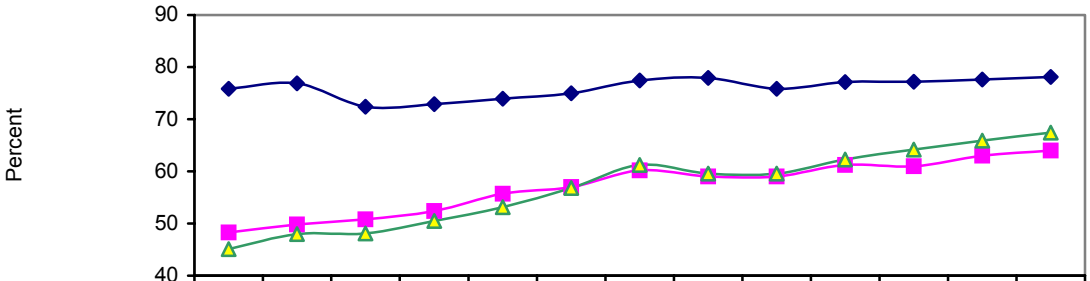
Figure 8. **Early (First Trimester) Prenatal Care**
New York State, New York City and Rest of State, 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	69.3	70.5	67.3	68.2	69.4	70.4	73.1	73.8	71.7	72.8	73	73	74.7
New York City	50.9	52.7	55.5	56.8	58.5	61	64.9	65.9	62.4	66	67.7	67.7	71.9
Rest of State	83.2	84	76.2	76.7	78.1	78	79.2	79.7	79.1	78.5	77.7	77.7	77.4

Early prenatal care rates in 2003 were slightly improved for African American and Hispanic/Latina moms. The Black-to-White ratio for early entry into prenatal care was 0.82, based on rates of 64.0% and 78.1%.

Figure 9. **Early (First Trimester) Prenatal Care**
By Race, NY State 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	75.8	76.9	72.4	72.9	73.9	75	77.4	77.9	75.8	77.1	77.2	77.6	78.1
Black	48.3	49.8	50.8	52.4	55.7	57	60.2	59	59	61.2	61	63	64
Hispanic	45.1	48	48.1	50.5	53.1	56.8	61.2	59.6	59.6	62.3	64.2	65.9	67.4

Adequacy of Prenatal Care: The Kotelchuk Index is a calculation based on the number of women ages 15 to 44 who had a live birth during the reporting year whose observed-to-expected number of prenatal visits is greater than 80%. In other words, this index tracks the percentage of women who have completed at least 80% of the prenatal visits that they would be expected to have completed. The Kotelchuk percentages for New York women ages 15 to 44 in New York were as follows:

Table 6. **Adequacy of Prenatal Care (Kotelchuk Index)**
Women Ages 15 – 44 years Who Gave Birth in that Year
By Region and By Race, 1990 - 2003

	Year →	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03
Region	New York City	42.3	43.9	44.4	45.8	48.7	52.5	55.4	56.1	57.6	57.6	56.6	56.5	57.8
	Rest of State	75.4	77.1	70.5	71.9	72.3	71.5	73.2	73.9	73.8	72.3	69.7	69.9	67.6
	Total NYS	61.0	62.7	59.2	60.3	61.8	63.1	65.6	66.4	66.9	65.6	63.5	63.6	63.1
Race	White	68.0	69.5	65.4	65.9	66.9	67.9	70.5	71.2	71.5	70.1	68.0	68.6	66.6
	Black	37.7	40.3	39.7	42.0	38.6	41.5	51.0	51.7	52.9	53.4	50.6	51.8	49.8
	Hispanic	38.0	40.8	39.5	42.0	46.0	50.1	54.0	55.5	56.2	56.1	55.0	57.1	55.8

Location of Prenatal Care: PRAMS responses indicate that 73.7% or more of women reported in 2002 that they received their prenatal care in physicians' offices (private MDs or health maintenance organizations). Other sources of care were hospital clinics (13.9%), and community health centers (4.4%). In the past few years, health department clinics provided less prenatal care: 5.7% in 1998, 4.6% in 2000, and 3.5% in 2001 and 2002.

Content of Care: PRAMS questions on prenatal care elicited responses to indicate that most women received educational information during their pregnancy on nutrition, drinking, smoking, and HIV testing. According to the 2002 survey, Of the 91.4% of women that recall education on HIV testing being given by their provider, 98.5% went on to be tested during their pregnancy. In 1998, 76.6% went on to be tested and in 2000, 81% went on to be tested. The percentage is steadily increasing.

The proportion on women who reported via PRAMS having read or heard about the importance of folic acid intake in prevention of birth defects increased from 67.9% in 1996 to 77.3% in 1998 to 85.1% in 1999. In 2002, women were asked if they could identify the reason folic acid is important in a multiple choice question. 90.6 percent of the women answered this question correctly.

Use of Alcohol and Tobacco during Pregnancy: 23.3% of women who responded to the PRAMS survey in 2002 reported that they had smoked in the three months prior to pregnancy (down from 24.7% in 2001), and though most reported that they reduced their smoking during pregnancy (14.6% in 2002 reported that they smoked in the last three months), many reported in 2002 that they returned to more frequent smoking after pregnancy than during pregnancy, and in doing so are exposing their infants to second-hand smoke. The percentage of those that smoked after pregnancy, however, was consistently lower than the percentage that smoked before pregnancy.

Women sampled also reported that they reduced the use of alcohol during pregnancy. In 2002, 54% reported drinking alcohol in the three months prior to pregnancy, but only 8.1% drank alcohol during the last three months of pregnancy. This percentage is up from 6.7% of the women sampled who reported drinking alcohol during pregnancy in 2001 and 6.5% in 2000.

Adult Smoking-New York City: According to a study commissioned by the New York City Department of Health and Mental Hygiene, the number of adult smokers in New York City declined by 11% from 2002 to 2003. This is believed to be one of the steepest short-term declines experienced in recent years. Researchers from Baruch College, who conducted the telephone survey, found that the number of regular smokers decreased by more than 100,000 between 2002 and 2003. The study also found that the number of cigarettes smoked by those surveyed declined by about 13%, indicating that people are smoking less. City health officials attribute this decline to tough anti-smoking laws and high cigarette taxes. These findings also coincide with a new state law that bans smoking in bars and restaurants and a city-wide anti-smoking campaign. (A later section of the Needs Assessment details youth smoking rates.)

Oral Health of Adults: The Behavioral Risk Factor Surveillance System (BRFSS) is the main source of data on the prevalence of dental diseases and risk factors in adults. It is an ongoing statewide telephone-based surveillance system designed by the Centers for Disease Control and Prevention (CDC). BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. New York State's BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older. The oral health module includes questions on tooth loss and use of dental services. The data on oral cancer are available through the Cancer Registry. In addition, the Pregnancy Risk Assessment and Monitoring System (PRAMS) provides data on risk factors in pregnant women.

Tooth Loss in Adults - Dental caries (tooth decay) and advanced periodontal (gum) diseases ultimately lead to loss of some or all teeth, if not treated in a timely manner. Tooth loss is indicative of the importance given to oral health, availability and accessibility of dental care and the prevailing standard of care. Loss of all natural permanent teeth not only considerably reduces daily functioning in terms of chewing and speaking, but also reduces self-esteem and quality of

life. According to the Behavioral Risk Factor Surveillance System, the percent of adults 65 years and older that had lost all their natural teeth was lower at each successive educational and income level.

Oral and Pharyngeal Cancers - These cancers are not usually an issue for the MCH population, but have implications for later in life. Some of the same risk factors for pregnant women and youth are risk factors for oral cancers.

Data from the New York State Cancer Registry show an annual average of 1,976 new cases and 506 deaths of oral and pharyngeal cancer for the period 1997-2001. An average of 1,290 new cases occurred in males and 686 in females. These oral and pharyngeal cancers account for approximately 3% of all malignancies in men and 1.5% in women. The age adjusted incidence rates per 100,000 for males and females are 15.4 and 6.4, respectively, with corresponding age adjusted mortality rates of 4.1 and 1.5 in the same period. Trends in incidence and mortality for oral and pharyngeal cancer in New York State show that both the incidence and mortality have declined in the last 2 decades, particularly among black males. However, black males still have the highest incidence and mortality rates. Despite advances in surgery, radiation and chemotherapy, the five-year survival rate for oral cancer has not improved significantly over the past several decades. The percent of cases diagnosed in early stage was 33.7 and 47.2 among males and females, respectively. African American's higher mortality can be partly attributed to the fact that their cancers are more often discovered at an advanced stage. Among black males, only 25.9% were diagnosed in an early stage.

Risk factors and protective factors for adult oral health include:

- Tobacco and Alcohol Use
  Tobacco use is one of the most common risk factors for oral cancer and other conditions in the mouth such as oral mucosal lesions, periodontal disease, gingival recession, and caries. The magnitude of the effect of tobacco on the occurrence of oral diseases is high, with users having many times the risk of non-users. Alcohol and tobacco use are the major risk factors for oral cancer, accounting for 75% of all oral cancers. According to the 2002 BRFSS, the statewide current use of tobacco is about 22.3%, which is similar to the nationwide usage of 23%. Tobacco use was highest among the 18 to 24 age group at 29.0% and least in the 65 + age group at 10.7%. Alcohol use in New York State is about 5%. It is highest in the 18 to 24 age group (14.1 %).

- Annual Dental Visits
  An annual dental visit presents an opportunity for providing preventive services as well as early detection of oral lesions. According to the 2002 BRFSS data an estimated 71.7% of New Yorkers reported visiting a dentist or a dental clinic within the past year. This compares favorably with the Healthy People 2010 Objective of increasing the proportion who uses the oral health care system each year to 56%. Low-income population visited a dentist less frequently compared to those with higher incomes (54 % vs. 73.8%).

Oral Health and Pregnancy - Evidence is emerging to show that poor oral health may be associated with adverse pregnancy outcomes. Several studies have shown the associations between periodontal disease and increased risk for preterm labor and low birth weight babies. Visits to a dentist during pregnancy are recommended to avoid the consequences of poor oral health. The use of dental services during pregnancy, as estimated from the Pregnancy Risk Assessment and Monitoring System (PRAMS) was 51.4% and 22.7% among white and black women, respectively. Because New York is concerned about the potential effect of poor oral health prior to and during pregnancy, and because of potential effects of maternal oral health on early childhood caries, and because there are no national standards for the oral health care of

women during pregnancy, New York has convened an expert panel of obstetricians, dentists and pediatricians to formulate guidelines for the oral care of women during pregnancy and the prevention of early childhood caries. It is anticipated that the guidelines will be ready Fall 2005.

Maternal Stress and Violence: Stress during pregnancy is linked to a number of social and reproductive risks. Not surprisingly, the greater the number of stressors that the women reported, the less likely the woman was to report, "Pregnancy was one of the happiest times of [her] life." In 2002, those describing pregnancy as "one of the happiest times of [their] life" reported an average of 1.2 stressors, while those that described pregnancy as "one of the worst times of [their] life" reported an average of 4.3 stressors.

In 2002, 29.7% of those surveyed reported that it was "one of the happiest times of [their] life." 2.6% reported that it was "one of the worst times of [their] life." Most reported that it was somewhere in between:

- 48.1% reported that it was "a happy time with a few problems;"
- 14.0% responded that it was a "moderately hard time;"
- 5.3% reported that it was a "very hard time."

PRAMS respondents in 2002 also reported that they experienced less physical abuse during pregnancy than in the 12 months before they were pregnant. 6.4% of women reported that they were physically abused in the 12 months before pregnancy, while 4.5% reported that they were abused during pregnancy.

Tracking of Selected PRAMS Responses, 1996 – 2002

Percent of mothers who reported that...	'96	'97	'98	'99	'00	'01	'02
...they drank alcohol during pregnancy	9.0	8.3	7.4	7.2	6.5	6.7	8.1
...they smoked prior to pregnancy	29	32	28	28.8	26.8	24.7	23.3
...they smoked during pregnancy	15.7	18.6	13.8	15.7	16.6	14.3	14.6
...they smoked after pregnancy	22.5	26.0	21.7	22.9	22.1	20.6	19.2
...they experienced physical abuse during prgy	4.4	4.9	3.0	4.9	4.0	4.2	4.5
...their pregnancy was unwanted or wanted later	34	38	35	35.1	37.8	33.8	34.3
...they initiated breastfeeding	62.2	63.0	65.4	65.4	70.4	69.4	72.1
...they put their babies to sleep on their side	42	35	30	25.1	20.4	16.4	15.3
...back	34	45	53	56.7	63.4	68.3	69.5
...stomach	24	20	17	18.2	12.6	16.1	15.2
...their babies were exposed to second hand smoke	11.4	9.4	6.0	6.6	9.2	9.3	7.6
...knew that folic acid can prevent birth defects	67.9	78.2	77.3	81.3	92.0	90.5	90.6

Prenatal HIV Counseling and Testing: In 2002, the number of HIV-infected women giving birth in New York State had decreased to 727. In 1990, there were 1,898 HIV-infected women who gave birth. This is a 62% decrease. In 1999, women represented 30% of total AIDS cases in the State.

Beginning in 2000, each HIV-infected woman who gave birth knew her diagnosis before or very shortly after delivery. Of the 830 HIV-infected women who gave birth in 2000, only 79 or 9.5% may not have known their HIV status prior to delivery. These women or their newborns received expedited testing in labor and delivery with the results available in time to administer drugs to reduce perinatal transmission.

Prenatal care enrollment among HIV-positive women is increasing. If women are enrolled in care, they can more easily obtain prenatal counseling and testing. The percent of HIV-infected women who received prenatal care increased to 92.4% in 2001, up from 88.5% in 1997.

An increasing percentage of prenatal women are receiving HIV counseling and testing. The percent of all women presenting for delivery who were tested during pregnancy increased in 2001 to 94% from 89% in 2000 and 46.7% in 1999.

Currently in New York, perinatal HIV counseling and testing are a standard of prenatal care. In 1996, the Department promulgated regulations requiring HIV counseling with testing recommended for all women in prenatal care in regulated facilities (licensed clinics, hospitals, and managed care plans). The Department worked with the American College of Obstetricians and Gynecologists, the New York State Academy of Family Physicians and the American Academy of Pediatrics to establish HIV counseling and testing as the standard of care. Compliance is monitored through chart review by a professional review agent, through the Quality Assurance Reporting Requirements (QARR) submission to the Office of Managed Care, and by own public health program nurses who monitor PCAP compliance.

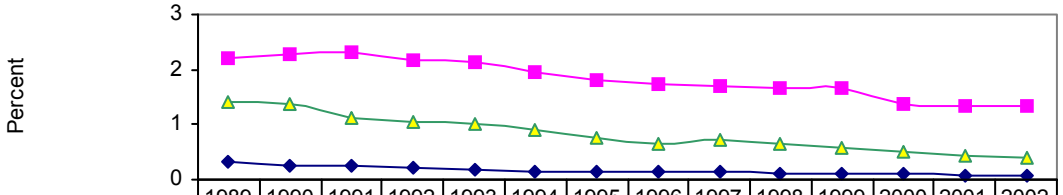
Perinatal HIV Transmission Rates: Perinatal HIV transmission rates declined by a dramatic 78% in New York State for infants born between 1997 and 2002. With the unbinding of HIV newborn screening results, and as the result of other State initiatives, the rate of perinatal HIV transmission has declined every year. Expedited testing meant fewer missed opportunities for prophylaxis of the newborns.

One year after the law took effect in 1997, the rate dropped to 8.4 percent and in 1999 the rate fell to 6.9 percent. Data for 2000 showed the perinatal HIV transmission rate at 3.5 percent -- more than meeting the ambitious goal set by Governor George Pataki. In 2002, the perinatal HIV transmission rate was reduced to 2.4%.

The percent of HIV-infected mothers-exposed infants who received prenatal, intrapartum or neonatal ARV to reduce HIV transmission increased from 63.1% in 1997 to 96.3% in 2000.

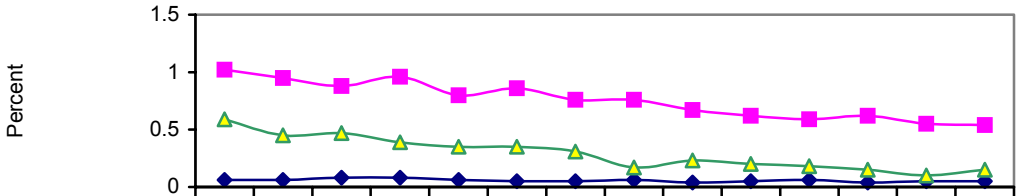
Perinatal HIV Seroprevalence Rates: Perinatal prevalence rates are significantly higher in African American and Hispanic/Latina women and significantly higher in New York City residents.

Figure 10. **HIV Prevalence in Childbearing Women**
New York City Residents by Race 1989 - 2002



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
White	0.33	0.26	0.26	0.22	0.19	0.16	0.14	0.16	0.14	0.11	0.11	0.1	0.07	0.08
Black	2.21	2.29	2.31	2.18	2.15	1.96	1.81	1.72	1.71	1.65	1.65	1.37	1.33	1.35
Hispanic	1.41	1.38	1.12	1.04	1.03	0.91	0.76	0.64	0.74	0.64	0.59	0.5	0.44	0.39

Figure 11. **HIV Prevalence in Childbearing Women**
New York State, Excluding NYC Residents, by Race 1989 - 2002

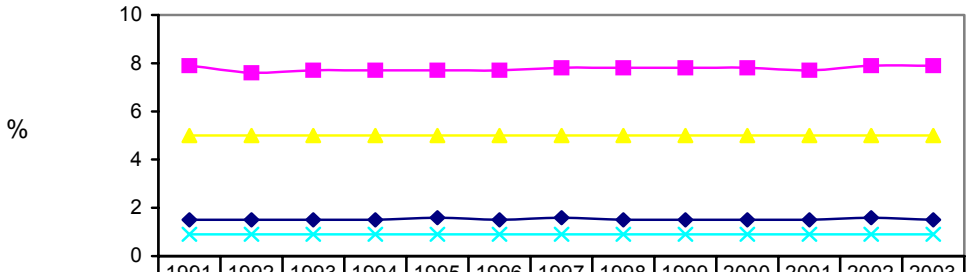


	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
White	0.06	0.06	0.08	0.08	0.06	0.05	0.05	0.06	0.04	0.05	0.06	0.04	0.05	0.05
Black	1.02	0.95	0.88	0.96	0.8	0.86	0.76	0.76	0.67	0.62	0.59	0.62	0.55	0.54
Hispanic	0.59	0.45	0.47	0.39	0.35	0.35	0.31	0.17	0.23	0.2	0.18	0.15	0.1	0.15

New York's partner/spousal notification law is in effect. The Department tracks the effects on HIV transmission rates. It is important to note that the law contains a mandate that providers screen for risk of domestic violence.

Low and Very Low Birth Weight: Changes in low birth weight rates for the last decade have not paralleled the decrease in infant mortality. Rates of births with infants weighing less than 1500 grams and less than 2500 grams have been relatively unchanged over the past ten years. The 2003 low birth weight rate of 7.9% is 58% greater than the Healthy People 2010 goal of 5.0%, and the rate of 1.5% for very low birth weight is 67% greater than the Healthy People 2010 goal of 0.9%.

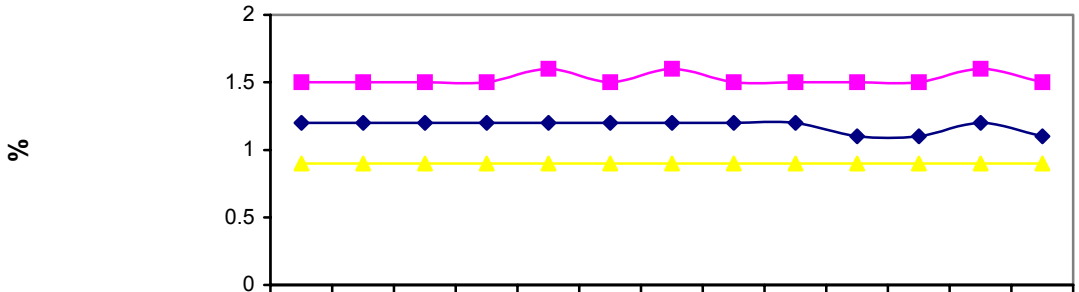
Figure 12. **Percent Low (<2.5 kg) and Very Low (<1.5 kg) Birth Weight**
New York Total Births 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Very Low Birthweight	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5	1.5	1.5	1.5	1.6	1.5
Low Birthweight	7.9	7.6	7.7	7.7	7.7	7.7	7.8	7.8	7.8	7.8	7.7	7.9	7.9
HP Goal/LBW	5	5	5	5	5	5	5	5	5	5	5	5	5
HP Goal/VLBW	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

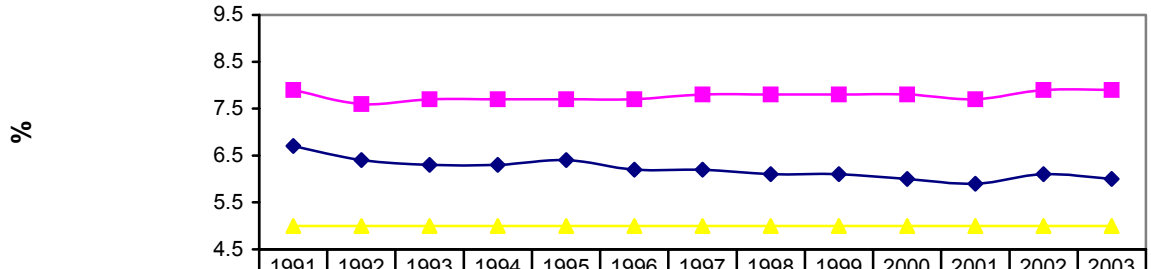
When low birth weight rates for total births are compared to those for singleton births, the latter shows a slight decreasing trend. Multiple births seem to be responsible for a portion of the lack of change in these rates over the last ten years. Multiple births are more common due to advances in the technology of assisted reproduction.

Figure 13. **Percent Very Low Birth Weight (<1500 gm)**
New York Singleton and Total Births 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Singleton	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.2	1.1
Total Births	1.5	1.5	1.5	1.5	1.6	1.5	1.6	1.5	1.5	1.5	1.5	1.6	1.5
HP Goal/VLBW	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

Figure 14. **Percent Low Birth Weight (<2500 gms)**
New York Singleton and Total Birth 1991 - 2003

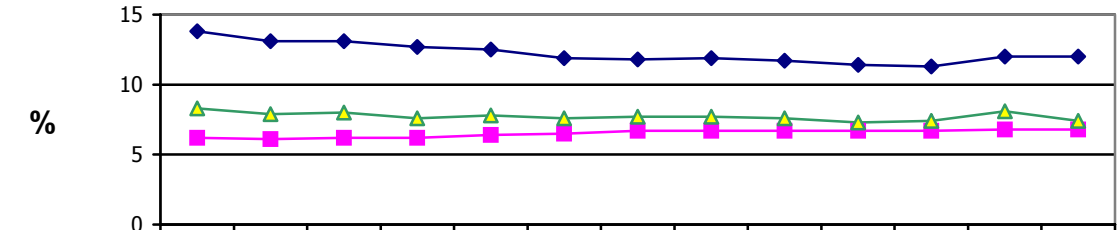


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Singletons	6.7	6.4	6.3	6.3	6.4	6.2	6.2	6.1	6.1	6	5.9	6.1	6
Total	7.9	7.6	7.7	7.7	7.7	7.7	7.8	7.8	7.8	7.8	7.7	7.9	7.9
HP Goal/LBW	5	5	5	5	5	5	5	5	5	5	5	5	5

WIC participants in New York State fare better than WIC participants nationwide as well as non-WIC participants in relation to low birth weight. In 2002, the percentage of low birth weight was 7.4% among NYS WIC participants, compared to 9.0% of WIC participants nationwide, and compared to a statewide total low birth weight rate of 7.9%. In 2004, the NYS WIC low birth weight rate was 7.7%, compared with 9.1% for WIC nationwide.

Disparities in Low Birth Weight: Disparities in low birth weight rates have shown improvement over time, but still persist. These disparities may be measured in the ratio of the Black low birth weight rate to the White low birth weight rate. The ratio has improved from 1991, when it was 2.2. The 1998 Black-to-White ratio for low birth weight based on the total number of births for each race was 1.8 based on rates of 11.9 and 6.7. In 1999, the ratio was 1.7, based on rates of 11.7 and 6.7. In 2000, the ratio was 1.7 based on rates of 11.4 and 6.7. The 2001 Black/White ratio remained at 1.7. In 2002 and 2003, it increased to 1.8. The trend is also seen in Black-to-White low birth weight rates for singleton births, a reduction from 2.5 in 1991 to 2.0 in 2000 and 2001. In 2002 and 2003, it was 2.1.

Figure 15. **Percent Low Birth Weight (<2.5 Kg.)**
NYS by Race 1991- 2003

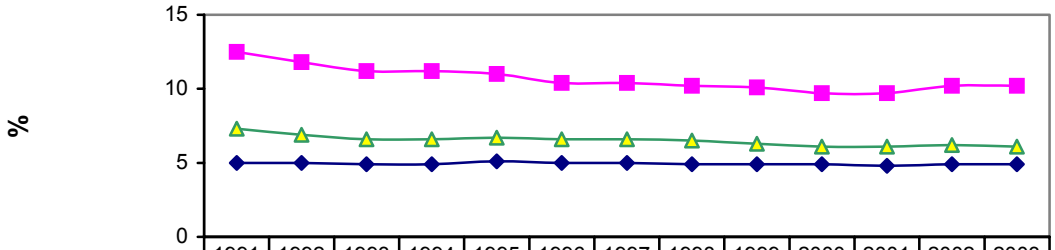


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Black	13.8	13.1	13.1	12.7	12.5	11.9	11.8	11.9	11.7	11.4	11.3	12	12
White	6.2	6.1	6.2	6.2	6.4	6.5	6.7	6.7	6.7	6.7	6.7	6.8	6.8
Hispanic	8.3	7.9	8	7.6	7.8	7.6	7.7	7.7	7.6	7.3	7.4	8.1	7.4

Table 7. **Ratio of Black Low Birth Weight Rate to White Low Birth Weight Rate –Total Births**

Year	1998	1999	2000	2001	2002	2003
Ratio	1.8	1.7	1.7	1.7	1.8	1.8

Figure 16. **Percent Low Birth Weight (<2.5 Kg.)**
NYS Singleton Births by Race 1991-2003



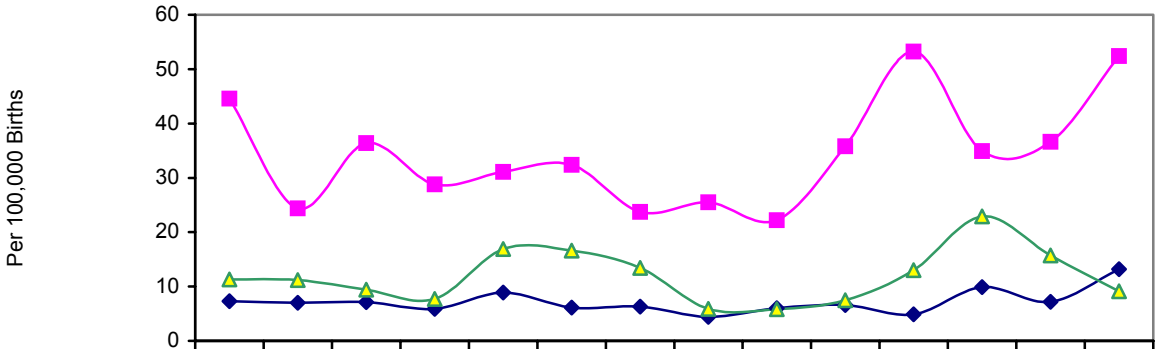
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	5	5	4.9	4.9	5.1	5	5	4.9	4.9	4.9	4.8	4.9	4.9
Black	12.5	11.8	11.2	11.2	11	10.4	10.4	10.2	10.1	9.7	9.7	10.2	10.2
Hispanic	7.3	6.9	6.6	6.6	6.7	6.6	6.6	6.5	6.3	6.1	6.1	6.2	6.1

Maternal Mortality: In 2003, New York's maternal mortality rate increased to 20.9 per 100,000 live births, primarily due to the increase in maternal mortality in the areas of the state outside New York City. In 2002, the rate was 13.2/100.000 live births. Prior to 1998, the rate had been declining. Between 1990 and 1997, the rate dropped 47% to an all-time low of 9.3 per 100,000 births. Between 1998 and 2001, however, the rate doubled to 20.1. The 2002 decline was the first since that time, but the decline did not continue in 2003.

The rate in 1997, when the rate was the lowest, is based on 24 maternal deaths. The rate in 2001 of 20.1 per 100,000 births was based on 51 maternal deaths. The 2002 rate of 13.2 is based on 33 maternal deaths. In 2003, there were 53 maternal deaths with a rate of 20.9 per 100,000 live births.

The maternal mortality rate in 2003 of 20.9 per 100,000 births is 6.3 times the Healthy People 2010 goal of 3.3 per 100,000.

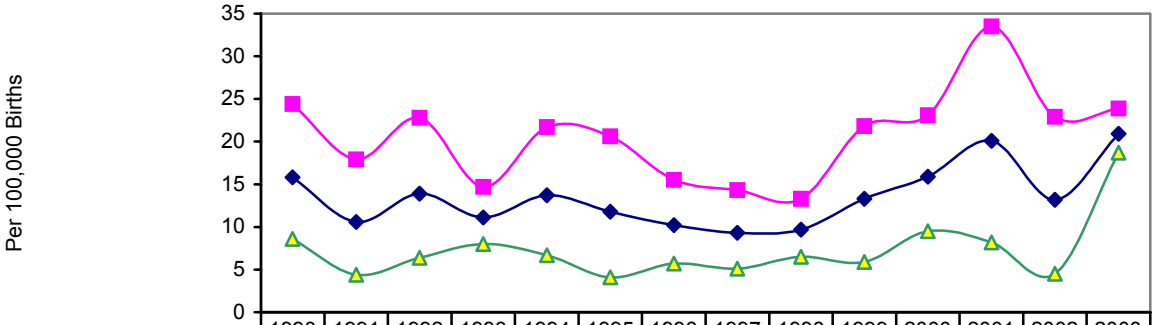
Figure 17 A: **Maternal Mortality Rate**
1990-1998 ICD9 Codes 630 to 676
1999-2002 ICD10 Codes 000-099
New York State Residents by Race 1990 - 2003



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	7.3	7	7.1	5.9	8.9	6.1	6.3	4.4	6	6.6	4.9	9.9	7.2	13.2
Black	44.6	24.4	36.4	28.8	31.1	32.4	23.7	25.5	22.2	35.8	53.2	34.9	36.6	52.4
Hispanic	11.3	11.2	9.4	7.7	16.9	16.6	13.4	5.9	5.8	7.5	13	22.9	15.7	9.1

The racial disparity in maternal mortality in New York is dramatic and exceeds the differences seen in infant mortality and low birth weight. The 2003 Black maternal mortality rate of 52.4 per 100,000 births compared to the White rate of 13.2 per 100,000 births, results in a Black-to-White ratio of four. These rates are based on 25 deaths among African American women, compared to 24 deaths among Caucasians. The rate for Hispanics in 2003 was 9.1, which is lower than the rates for Caucasians and Blacks.

Figure17 B: **Maternal Mortality Rate**
1990-1998 ICD9 Codes 630 to 676
1999 - 2003 ICD10 Codes 000 to 099
New York State, New York City and Rest of State 1990 - 2003



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	15.8	10.6	13.9	11.1	13.7	11.8	10.2	9.3	9.7	13.3	15.9	20.1	13.2	20.9
New York City	24.4	17.9	22.8	14.7	21.7	20.6	15.5	14.3	13.3	21.8	23.1	33.5	22.9	23.9
Rest of State	8.6	4.4	6.4	8	6.7	4.1	5.7	5.1	6.5	5.9	9.5	8.2	4.5	18.7

In part, wide fluctuations in the rate are related to the rarity of the occurrence. The small numbers of deaths that occur each year create great swings in rates.

There are many reporting issues related to maternal mortality that contribute to inconsistent rates. For example, if investigators rely solely on the death certificates to identify maternal deaths, the relationship of certain conditions to a previous pregnancy may not be clear, and the death may never be classified as a maternal death. The greater the efforts made toward ascertainment of a previous pregnancy, the more likely investigators are to identify a true maternal death.

If the health care provider completing the death certificate does not connect the death to a recent pregnancy, the death is frequently reported under a non-maternal cause. Working with the NYS Chapter of ACOG through the Safe Motherhood Initiative, the NYSDOH have been working to increase awareness of maternal mortality which may have improved the completeness of maternal death reporting through death certificates.

B. Children

Childhood Nutrition: A total of 476,563 participants enrolled in New York's Supplemental Food Program for Women, Infants and Children (WIC) in FFY 1999. Another 1,774,646 children participated in the School Lunch Program, and there were 243,052 participants in the Child and Adult Care Food Program (CACFP) in New York in the same year. Food Stamps reached about 800,000 children.

According to the 2003 Youth Risk Behavior Survey, twenty-four percent of adolescents (comparable to 26% of adults) in New York State consumed at least five fruits or vegetables per day. While 39% of New York adolescents eat two or more fruits per day, only 15% consume at least three portions of vegetables. Consumption of fruits and vegetables diminishes with grade. Differences by gender and race were insignificant.

Respondents to WIC participant surveys reported an increase in the number of children drinking low fat or skim milk from 5.4% in 1998 to 8.9% in 2000. Responses on numbers of fruits and vegetables consumed per day increased in the same time period from 2.8 to 3.0 servings of fruit and from 1.6 to 1.7 servings of vegetables a day. While improvement is encouraging, this is still below the recommended servings per day.

Breastfeeding: New York uses PRAMS data to track breastfeeding trends. Through 1999, the PRAMS breastfeeding question was asked as follows: "For how many weeks did you breastfeed your baby?" Possible responses were: "I didn't breastfeed my baby." "I breastfed less that one week." "I am still breastfeeding." Also, through 1999, there was a New York State-specific question on why the mother didn't breastfeed.

In 2000, additional breastfeeding questions were added to the survey. The question is now asked: "Did you ever breastfeed or pump your breast milk to feed your new baby?" "What were your reasons for not breastfeeding your baby?" "How many weeks did you breastfeed or pump milk to feed your baby?" "What were your reasons for stopping breastfeeding?" "How old was your baby the first time you fed him or her anything besides breast milk?"

PRAMS data show that rates of breastfeeding initiation improved. There was a 5% improvement between 1999 and 2000, but there is not certainty as to whether this is due to the change in the way the questions were asked in 2000.

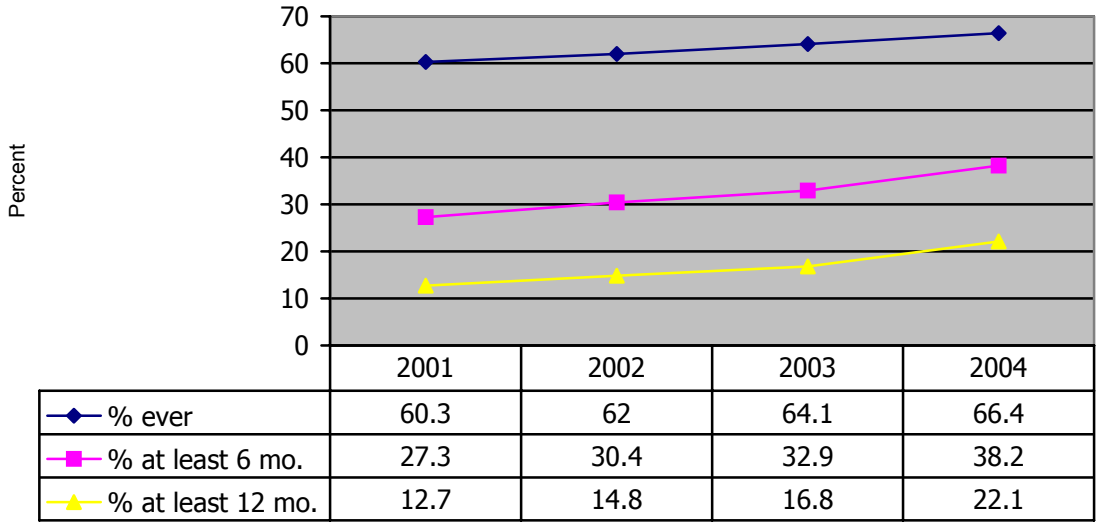
Highlights from the PRAMS 2002 data are as follows:

- Breastfeeding rates have shown slight, but steady improvement over the last few years.
- Breastfeeding rates drop dramatically one month postpartum.
- Mothers with more than 12 years of education were more likely to breastfeed.
- The percent of African American mothers who initiated breastfeeding improved dramatically from 1996 to 1999, going from 51% to 72%, respectively. In 2000, the rate had improved to 74.7%, but dropped again in 2001 to 67.2%. In 2003 there was slight improvement to 68.1%.
- Marriage increases the likelihood that mothers will initiate breastfeeding and continue to breastfeed past the immediate postpartum period. Among married women responding in 2002, 75.6% initiated breastfeeding, compared to 62% for unmarried women.
- Of the 27.9% that chose not to breastfeed in 2002, 48.2% stated that they did not do so because they did not like breastfeeding, and 34.1% indicated that they didn't because they had other children to care for. 30% said they had to return to work or school.

Breastfeeding Initiation and Duration for PRAMS Respondents 1996 – 2002 *Source: PRAMS data*						
Year>	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
PRAMS – Initiation	63.0%	65.4%	65.4%	70.4%	69.4%	72.1%
PRAMS – 1 Mo. Postpartum	52%	52%	50%	55.3%	53.6%	57.6%

WIC breastfeeding data is showing slight improvement. In 2004, 66.4% of WIC moms reported ever breastfeeding. This is a 10% increase over 2001. At 12 months, 22% of WIC participants reported in 2004 that they were still breastfeeding. This is 32% more than in 2003 and almost double the rate reported in 2001.

Figure 19
Trends in Breastfeeding 1999-2003
Source: Pediatric Nutrition Surveillance - WIC



	2001	2002	2003	2004
% ever	60.3	62	64.1	66.4
% at least 6 mo.	27.3	30.4	32.9	38.2
% at least 12 mo.	12.7	14.8	16.8	22.1

A recent study, which utilized National Maternal and Infant Health Survey data, found that breastfed children have a decreased risk of post-neonatal death, compared to those who are never breastfed. The study, published in **Pediatrics,** found that:

- Overall, children who were ever breastfed had 0.79 times the risk of post-neonatal death, compared to those who were never breastfed.
- Most of the infants who died were less than age four months.
- Longer breastfeeding was associated with lower risk of post-neonatal death.
- The mothers of children who died were younger, less educated and smoked more often during pregnancy.
- The infants who died tended to be of higher birth order, and were more often male, African American and low birth weight.

National Immunization Survey Data on Breastfeeding: Each year since 1994, the CDC National Immunization Program, in partnership with CDC's National Center for Health Statistics, has conducted the National Immunization Survey (NIS) within all 50 states, District of Columbia, and selected geographic areas within the states. Since January 2003, breastfeeding questions have been asked of all survey respondents selected to participate in the National Immunization Survey (NIS). All data collected on breastfeeding in this survey relates to the child about which immunization data is being collected. As a result, the 2003 NIS results provide geographically-specific breastfeeding rates for the initiation, duration, and exclusivity of breastfeeding:

- In 2003, 71.4 percent of women in New York State reported ever-breastfeeding. Women in New York City were more likely (73.1%) to report ever breastfeeding as compared to women in Upstate (69.9%). New York State Women were slightly more likely to report ever breastfeeding than women nationwide.
- About one-half of the NY state women reporting ever breastfeeding were still breastfeeding when their babies were 6 months of age (35.3%). Rates were similar for Upstate, NYC, and the nation. If only looking at women exclusively breastfeeding at 6 months of age, which is recommended by the American Academy (AAP) of Pediatrics, 14.2 percent of women in New York State were in this category. Slightly more NYC moms reported excusive breast feeding at 6 months of age (16.5%), as compared to Upstate (14.2%) and the nation (14.2%).
- New York State has not yet achieved the national *Healthy People 2010* objective of 75% of mothers initiating breastfeeding. According to the CDC, only 14 states have achieved this goal.

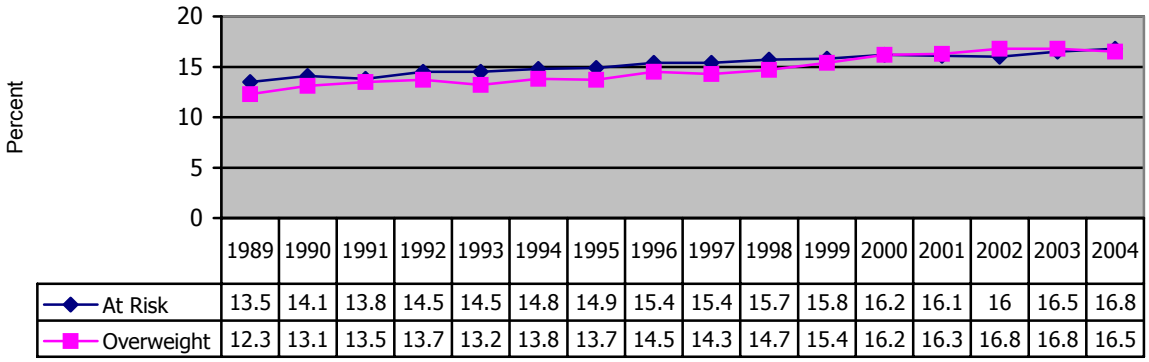
Breastfeeding Patterns Of Participants In The National Immunization Survey
New York State By Region And US , 2003

Region	Ever Breastfeeding	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive at 3 months	Exclusive at 6 months
Upstate	69.9+/-5.1	34.6+/-5.1	17.1+/-3.9	35.2+/-5.1	12.3+/-3.4
New York City	73.1+/4.1	36.2+/-5.1	17.4+/-4.0	42.6+/-5.4	16.5+/-4.0
New York State	71.4+/-3.5	35.3+/-3.6	17.1+/-3.9	38.6+/-3.7	14.2+/-2.6
US	70.9+/-0.8	36.2+/-0.8	17.2+/-0.7	41.1+/-0.9	14.2+/-0.6

Childhood Overweight: There is growing concern about the national epidemic in childhood overweight and adult obesity. A study conducted among a representative sample of second and fifth graders in 1990 showed that 35% of the children in New York City are overweight, as were 28% of the children in the rest of the state. Among preschoolers in the 1998 WIC population, there are twice as many overweight children as would be expected. Research indicates that adult morbidity and mortality are increased by childhood obesity, even if the condition does not persist into adulthood. Among adolescents responding to the 2003 YRBS, 35.3% of the females and 24.5 % of the males thought they were overweight. Based on the Body Mass Index information from this study, 9.3% of females and 16.4% of males responding were overweight.

In 2004, 16.5% of the two- to four-year-olds participating in New York's WIC Program was overweight. This is a 35% increase since 1989. The percent of overweight children varies considerably by race and ethnicity. Hispanic children are almost twice as likely to be obese than Black or White children.

Trends in Overweight and At-Risk for Overweight
Among WIC Program Children Ages 2 to 4 Years
1989 - 2004
Source: WIC Program



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
At Risk	13.5	14.1	13.8	14.5	14.5	14.8	14.9	15.4	15.4	15.7	15.8	16.2	16.1	16	16.5	16.8
Overweight	12.3	13.1	13.5	13.7	13.2	13.8	13.7	14.5	14.3	14.7	15.4	16.2	16.3	16.8	16.8	16.5

At risk of overweight= BMI greater than 85th percentile, less than the 95th percentile
Overweight= BMI greater than or equal to the 95th percentile
Both measured by age- and sex-specific 2000 CDC growth charts

In 1996, NYSDOH conducted a survey of elementary students in New York City and found that 20% of third graders and 21% of sixth graders were overweight (BMI ≥ 95%ile). Overweight in this study was also more prevalent in males and in African Americans. New York City rates were substantially higher than national rates for children of the same age. NYSDOH is currently conducting a survey of a representative sample of third graders to determine overweight rates.

Data from the 2003 YRBS found that 12.9% of adolescents are overweight (BMI ≥ 95%ile). Adolescent males had a significantly higher rate than females and African American adolescents had a significantly higher rate than white adolescents.

The 2003 BRFSS found 57.3% of New York adults were overweight or obese, which has implications for women of childbearing age. The overweight/obesity rate increases with age, from 35.3% among 18 to 24 year-olds to 69.5% among 55 to 64 year olds. Rates are higher among men than women (64.1% vs. 51%) and higher among African Americans (70.2%) and Hispanics (59.4%) than whites (56.3%). Rates are also significantly higher among those with less education.

The vision is for all New Yorkers to achieve and maintain and healthy weight. NYSDOH's mission includes decreasing the prevalence of overweight and obesity and to reduce the burden of obesity-related diseases by improving healthy eating and increasing physical activity. Over the past two years, the department and many partners and stakeholders have been involved in developing the *New York State Strategic Plan for Overweight and Obesity Prevention.* This plan includes a role for individual behavioral change, but also focuses on population-focused preventions efforts for policy, environmental and systems change. These large-scale strategies are designed to decrease barriers to healthy food choices and exercise opportunities, and to increase the ease of making healthy food and physical activity choices by making them accessible in childcare, schools, worksites, healthcare setting and in the community, making changes more sustainable than individual or group education strategies.

The following ten goals were identified to guide New York's efforts:

- Increase awareness of overweight and obesity as a major public health threat;
- Increase early recognition of overweight and/or excessive weight gain;
- Improve management, both medical and non-medical, of people who are overweight or obese and those with obesity-related diseases;
- Increase initiation, exclusivity and duration of breastfeeding during infancy;
- Improve lifelong healthy eating;
- Improve lifelong physical activity;
- Decrease exposure to television and other recreational screen time;
- Increase policy and environmental supports for physical activity and healthy eating, including breastfeeding;
- Increase and maintain effective public health responses to the obesity epidemic in New York State; and
- Expand surveillance and program evaluation to prevent overweight and obesity.

Title V will continue to work with colleagues in the Division of Chronic Disease Prevention and Adult Health and the Division of Nutrition to meet the challenges of this epidemic.

Nutrition Assistance: According to the US Department of Agriculture, food insecurity in New York State is thought to be in the range of 10% (±0.74) and food insecurity with hunger is thought to be in the range of 3.9% (±0.31%). Approximately 56% of all licensed childcare entities participate in the Child and Adult Care Feeding Program.

Physical Activity: According to the 2003 YRBS, 22.8% of adolescents were estimated to participate in moderate physical activity for at least 30 minutes on at least five or more of the past seven days. There were no substantial differences noted by race, grade or gender.

In 2003, 43.6% of New York State adolescents watched three or more hours of television per day, according to the YRBS. Higher rates were noted in New York City, where 59% of students reported watching three or more hours per day. A study of WIC participants found that hours of television viewing were higher in African American and Hispanic preschoolers than white preschoolers. Preschool WIC participants with a television in their bedroom spent more time watching and were more likely to be overweight than children without a television in their bedroom.

Oral Health Status of Children: In the United States and in New York, dental caries in children is the most common chronic disease. Nationally, a progress review toward Healthy People 2010 observed that the prevalence of dental caries in 2-4 year old children was approximately 23% (HP 2010 Target 11%). Of children aged 1-5 years enrolled in the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), only 16% received any preventive service. A survey of a disadvantaged group of children in northern Manhattan found a high level of unmet need (1).Because management of children of this age group in a dental office is difficult, many children require treatment in an operating room. In New York, approximately 2900 children younger than 6 years of age visit a hospital annually for dental caries.

Cleft lip and cleft palate are one of the most common congenital anomalies. These conditions may occur as isolated defects or as part of other syndromes. In the United States, the prevalence rates in the general population have been reported to be approximately 1.2 per 1000 births for cleft lip with or without cleft palate and 0.56 per 1000 births for cleft palate alone (2). In Year 2000, there were 183 cases of cleft lip with or without cleft palate (0.71 per 1000 births) and 143 cases of cleft palate (0.55/1000 births) in New York State. The rate of oral clefts has been reported to be higher among whites compared to that for blacks (2). In New York State, the rate varied from 0.8 to 1.5/1000 births in different racial and ethnic groups.

According to a survey of 3rd grade children conducted during 2002-2004 by the New York State Health Department in collaboration with many partners, the prevalence of dental caries was 54.1%. The estimated percent of children with untreated caries was 33.1%. The Healthy People 2010 (HP 2010) target for caries experience and untreated caries for 6-8 year old is 42% and 20% respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group.

Protective factors for oral health include:

- Water Fluoridation
  More than 12 million New Yorkers receive fluoridated water. The percent of the population on community water supplies receiving fluoridated water is approximately 70%, compared to the Healthy People 2010 Objective of 75%. The percent of the population on fluoridation was 100% in New York City and 46% in upstate New York. Counties with large proportions of the population not covered by fluoridation are Nassau, Suffolk, Rockland, Ulster, Albany, Oneida and Tompkins.

- Fluoride Use

  Fluoride tablets are prescribed to children living in areas where water is not fluoridated in upstate New York State communities. (New York City children receive fluoride from water.) About 30.5% and 17.7% of high income and low income children respectively in upstate New York reported the use of fluoride tablets on a regular basis.

- Dental Sealants
  The estimated percent of children with a dental sealant on a permanent molar in New York State was 17.8% and 41.1% in the low and high-income groups respectively. Again, a lower proportion of low-income children had dental sealants compared to that of high income children.

- Insurance Coverage
  Approximately, 80.1% of children reportedly had some type of dental insurance coverage. There was no noticeable difference in the insurance coverage between high and low-income groups.

- Dental Visit in the Past Year
  The percent of children with a dental visit in the past year was 73.4%. While there was no noticeable difference in the insurance coverage between high and low income groups, a lower proportion of low income children had visited a dentist in the last one-year (60.9% vs. 86.9%).

- Use of Dental Services in Medicaid and Child Health Plus Programs
  For those New York State children aged 4 to 21, who are continuously enrolled for a year in 2003, 45% in Medicaid and 40% in Child Health Plus program visited a dentist.

A major risk factor is tobacco use in children. According to the 2002 New York State Youth Tobacco Survey (3), the current use of cigarettes among middle school and high school students is approximately 6.7% and 21% respectively. Among high school students, the current use of cigarettes for white, black and Hispanic students was 23.3%, 11.9% and 18.3% respectively.

Childcare: In New York, more than half of mothers with children younger than age 13 are employed. Childcare is a major issue for working families. Each family needs to decide who will care for their children while they work and, for their peace of mind, needs to feel comfortable that their child is safely cared for in a supportive, nurturing environment.

In June 2004, the Urban Institute released a report entitled, "State Profile of New York: Data from the 2002 National Survey of America's Families". According to the report, among NYS full-time employed mothers with children under 5, 35.8 percent of the children spend about 35 hours per week in nonparental care. Nationwide the figure is 38 percent. In NYS, center-based care accounts for 24.5 percent of the arrangements for kids under 5 years of age. Other arrangements are Family Childcare (12.6%), Relative (24.7), babysitter/nanny (7.4%) and parent/other (31.0%). On the average, working families who pay for childcare spend one out of every ten dollars they earn on childcare.

The 2000 US Census provided further information. According to the Census, 55.8% of children under age 6 have both parents working; 65.5% of children 6 to 17 years of age have both parents working. An estimated 139,135 of 496,212 grandparents with their own grandchildren under age 18 in the home are responsible for their grandchildren. About 83,802 of those children are under age 5; about 55,333 are over age 5.

The growing use of self-care for children is of great concern. Self-care means that an adult does not directly supervise children. The uses of self-case increases as children grow older. Almost 20% of 6- to 9-year olds whose moms are employed are in before- and/or after-school care, but less than 10% of 10- to 12-year olds are in such programs. Fewer than 10% of 6- to 9-year olds spend any time in self-care on a regular basis, compared to more than 25% of the 10- to 12-year olds.

The Office of Children and Family Services (OCFS), who licenses and regulates these facilities in this State, reports in 1999 there are a total of 28,208 licensed facilities in the State, providing day care to 556,783 children, when they are at capacity. Of these facilities, 15,970 (56.6% of the total facilities) are located in New York City, serving 299,120 children (53.7% of all children served). It is important to keep in mind that these data reflect only licensed facilities, and not more informal arrangements.

Figure 18. **NYS Capacity by Types of Child Care**

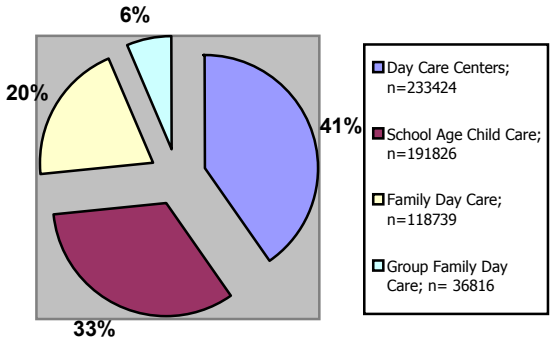
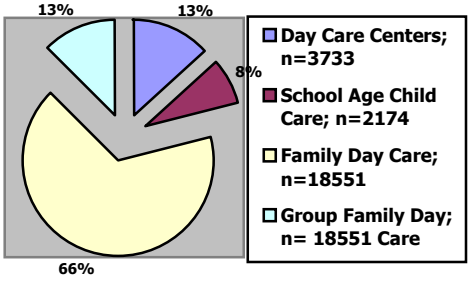


Figure 19.
NYS Child Care
% Children Enrolled by Types of Care



Recently, Governor George Pataki and State Comptroller Alan Hevesi announced a new initiative to make home-based day care setting safer and more closely supervised. The state's 58 local social services districts will be increasing inspections of those family care settings that have been exempt from OCFS licensure requirements. This type of childcare is generally provided by relatives, friends and neighbors, and involves only one or two children at a time. Under this new initiative, providers and household members will undergo checks for criminal history and history of abuse or neglect of children. The new rules also make it a crime for a provider to provide false information on child care subsidy enrollment forms. Annually, onsite inspections will be conducted for at least 20% of the active providers of this type not participating in the Child and Adult Care Food Program. The Child Care Resource and Referral Agencies will also be increasing their efforts to improve the safety and developmental appropriateness of this form of care.

There are currently over 100 trained Childcare Health Consultants across the State. These consultants are mostly public health nurses or public health educators who work for local health departments. Training will take place in the western portion of the state within the next few months, which is projected to increase the number of Childcare Health Consultants in that area.

A total of 49,473 New York children participated in the Federal Head Start program in FFY 2003, up from 45,608 in FFY 1998, 45,040 in FFY 1999, and 46,805 in 2000.

According to the NYS Department of Labor, salaries for child care workers in New York State in 2004 ranged from an average annual income of $15,110 for entry level workers to $24,920 per year for experienced workers. The average earnings were $21,650 annually. This is an improvement in wages from 1998, when the average annual income of a childcare worker in New York was $16,890.

Young Children of Migrant and Seasonal Farmworkers - The Agri-Business Child Development in 2004 released a Needs Assessment of the children and families enrolled in their migrant and seasonal Head Start Program. Family needs included:

- Child care for school-aged children who are over the age for services of Head Start;
- Assistance with transition to public school;
- English as a Second Language (ESL) and high school equivalency diploma (GED) classes;
- Help with overcoming barriers to enrolling and utilizing insurance;
- Help with successfully completing follow-up services for children referred to dental care and to specialists, given the short timeframe during which the family remains in any given area;
- Access to bi-lingual, bi-cultural mental health providers and removing the stigma of using mental health services; and
- Assistance with enabling services, such as transportation and translation.

Many parents felt it was critical that children speak English prior to entering kindergarten. Parents also link their success with English to greater economic success for themselves and their families. Less than 2% of the parents of the Head Start children have a high school diploma or its equivalent. They state that onsite childcare is a significant factor in whether they are able to take part in ESL or GED classes.

With regard to health and dental services, parents reported that sometimes their coverage lapses. They point out sometimes, due to the nature of their employment and the time it takes to process applications, their applications or re-applications are pending in one areas when they move on to other areas of the state. Families also reported being confused by HIPPA paperwork. The Head Start Program is working diligently with their community partners and state agencies (such as the Migrant Health Program) to overcome the lack of Spanish language materials and translators, and to improve access throughout the state for migrant children and their families.

Ambulatory Care Sensitive Conditions: Conditions are considered "ambulatory care sensitive" if early care and treatment make hospitalization avoidable. Two conditions often tracked as ambulatory care sensitive are asthma and otitis media (middle ear infection).

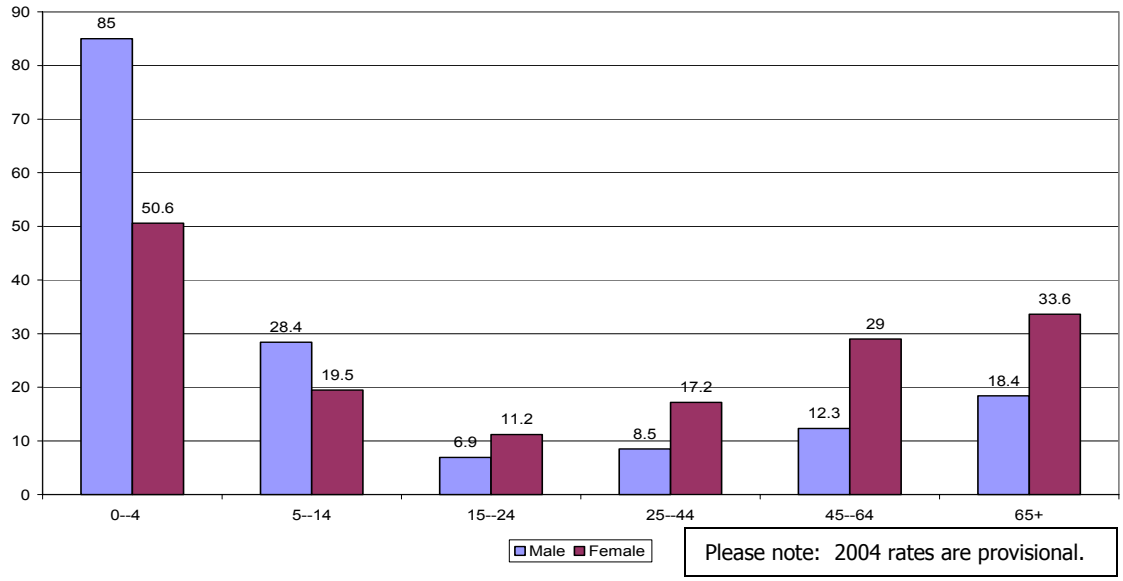
Asthma Hospitalizations: Between 1994 and 1997, asthma hospitalization rates for children aged birth to four years increased 7% to 86.6 per 10,000. According to 1998 hospitalization data, the 1998 rate was 63.9 per 10,000, a 26% drop from the previous year. This dramatic drop warranted further investigation. We have been unable to find problems with the data, but are still reluctant to say that this was a true decline.

In 1999, the rate climbed again to 81.6 per 10,000 children. In 2000 we again saw a dramatic drop in the rate to 63.1 per 10,000 children. The 2001 rate was slightly above that count at 66.6/10,000. In 2002, the rate declined to 65.4. In 2003, however, the rate was up to 72.7 per 10,000. Asthma hospitalizations continue to be almost 3 times more frequent in New York City than in the rest of the State. Both areas experienced an increase in hospitalizations in 2003.

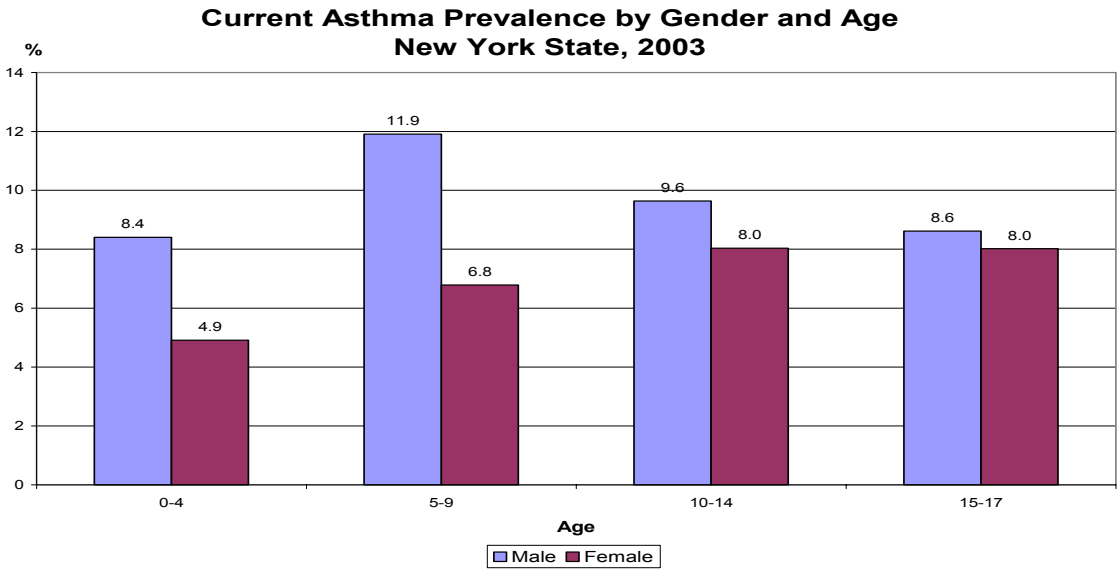
Asthma and Otitis Media Hospital Discharge Rates per 10,000
Children Birth thru Four Years of Age, New York State, New York City and Rest of State, 1994-2003
Source: SPARCS

Condition	Region	1995	1996	1997	1998	1999	2000	2001	2002	2003
Asthma	Rest of State	43.2	38.3	40.8	31.8	40.5	33.2	35.9	35.5	40.2
	New York City	156.8	148.2	148.9	107.5	137.0	101.7	106.2	101.4	110.1
	New York State Total	90.9	84.7	86.6	63.9	81.6	63.1	66.6	65.4	72.7
Otitis Media	Rest of State	7.7	5.9	5.6	5.0	5.9	4.9	3.6	4.1	2.9
	New York City	23.6	19.4	17.4	13.1	12.3	10.3	8.8	8.2	8.2
	New York State Total	14.4	11.6	10.8	8.4	8.6	7.3	5.9	5.9	5.3

Average Annual Asthma Hospitalization Rate Per 10,000 Residents
by Age and Gender, New York State, 2002-2004



When looking at asthma hospitalizations by age and gender an interesting pattern exists. At ages under 15 males have a higher rate of hospitalization. However, after age 15 females account for a higher percentage of asthma hospitalizations. This is especially significant for women during child bearing years because asthma can cause complications during pregnancy and must be monitored closely.



Recently, 2003 data from the National Asthma Survey for New York State became available. At ages 0-4, 8.4 percent males and 4.9 percent of females reported they had been diagnosed with asthma. Among males ages 5-9, 11.9 percent reported being diagnosed with asthma compared to 6.8 percent of the females. Interestingly, at ages 15-17 the percent of males with asthma dropped to 8.6 percent while the females increased to 8.0 percent.

National Asthma Survey **Children ages Birth through 17** **New York State - 2003**	
Children <18 years	**Percent with Asthma**
Total	8.4%
Gender	
Male	9.8%
Female	6.9%
Race/Ethnicity	
White	7.3%
Black	10.0%
Hispanic	10.9%
Household Income	
<$10,000	11.5%
$10,000-$14,999	12.2%
$15,000-$19,999	7.5%
$20,000-$29,999	8.7%
$30,000-$39,999	10.6%
$40,000-$49,999	9.2%
$50,000-$74,999	9.4%
$75,000-$99,999	8.1%
$100,000+	6.1%

In 2003, asthma in New York State among children less than 18 was more prevalent among blacks and Hispanics and children living in homes with incomes below $15,000 per year.

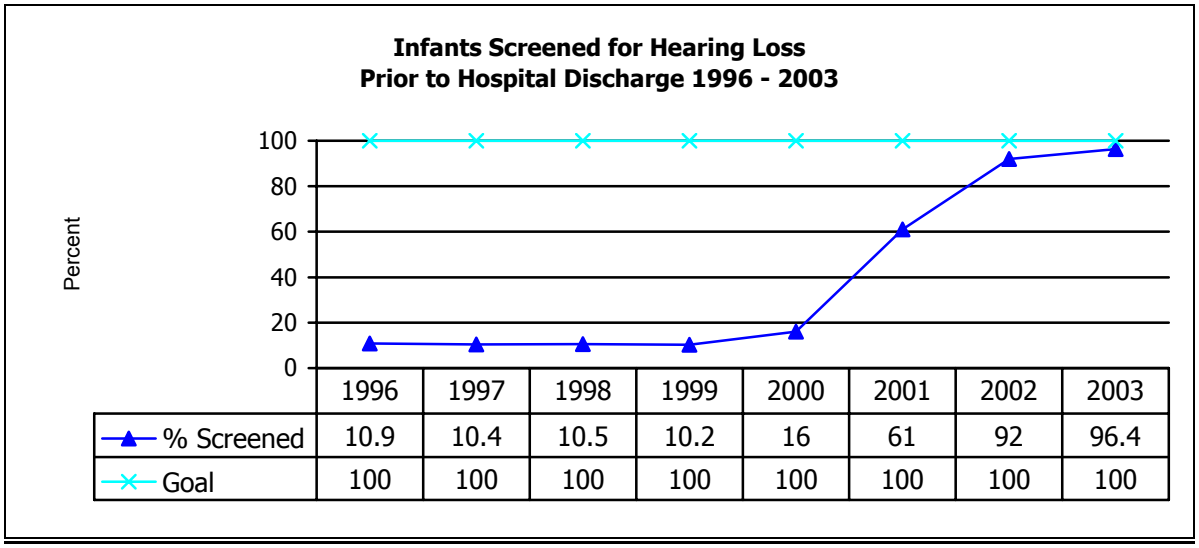
Otitis Media: Otitis media hospitalizations have declined over the past nine years. In 2003, 5.3 per 10,000 children aged birth to four were hospitalized for otitis media. This is down 63% from 1995 when the rate was 14.4 per 10,000. A significant difference in rates exists between New York City and the rest of the State. Rates in New York City declined 66% from a high of 26.6 per 10,000 in 1995 to 8.2 per 10,000 in 2003. The rest of the State also experienced significant declines, although the rates are much lower. (See table above)

Childhood Lead Poisoning: Progress continues to be made in protecting New York's children from lead poisoning. Childhood lead poisoning is a serious health problem that can have a devastating effect on the child, and that has serious repercussions for society as a whole. Human interaction with lead in the environment is most dangerous for children under the age of six. Exposure to even small amounts of lead can contribute to behavior problems, learning disabilities and lowered intelligence. Screening and prompt and effective intervention have been shown to prevent some of the more advanced effects of lead poisoning, such as seizures and severe kidney and nervous system damage.

Provisional data not yet released from the New York State Department of Health Childhood Lead Poisoning Prevention Program, exclusive of New York City for the years 2002-2003 showed that:

- The incidence and prevalence of lead poisoning in the period 2002-2003 declined across all categories and all blood lead levels, and screening rates continued to improve.
- The number of children newly identified with lead poisoning, defined as children with blood lead levels of 10 micrograms per deciliter or higher, declined.
- In 2003 the incidence rate declined to 1.57 from a 2002 incidence rate of 1.67. In 2002, the prevalence rate of children with levels of 10 micrograms per deciliter or greater was 2.6%. In 2003, the prevalence rate decreased to 2.5%.
- The number of children with higher blood lead levels requiring environmental intervention, defined as 20 micrograms per deciliter or higher, was stable over this period as expected, leveling off of the dramatic declines experienced in previous years. While total number of children declined an additional 4% over the two years studied from 440 in 2002 to 422 in 2003, incidence rates remained stable at 0.23 per 100 children screened.
- New York's lead screening rate remained at a high level. Analysis of screening rates for the 2000-2001 birth cohorts of children under age two shows New York's screening rates have increased from 66.6% in children born in 2000 to 67.6% for children born in 2001.
- The screening rate for those children enrolled in Medicaid managed care was higher than for the rate for the state as a whole. Seventy-six percent of children enrolled in Medicaid managed care programs were screened for blood lead in New York State.
- New York City reported a similar decline in new childhood lead poisoning cases. The New York City Department of Health recently released 2003 annual report showed stable incidence of childhood lead poisoning over the period from 2002 to 2003. The number of new cases of children from birth through seventeen years of age with elevated blood leads of ten micrograms per deciliter or higher declined. In 2003 the incidence rate declined to 1.10 from a 2002 incidence rate of 1.29. The number of children with higher blood lead levels requiring environmental intervention, defined as 20 micrograms per deciliter or higher, remained stable from 520 cases in 2002 to 519 cases in 2003. Due to differences in methodology, these data cannot be directly compared to those figures for the rest of the State.

Universal Newborn Hearing Screening: Since the passage of legislation mandating the screening of all newborns for hearing deficits, the percentage of newborns screened before hospital discharge has steadily risen. New York conducted a pilot program from 1996 to 1999 that included all regional perinatal centers and high-risk nurseries in the State, which provided a strong foundation for launching universal screening.



Infants Screened for Hearing Loss Prior to Hospital Discharge As a Percentage of Total Births *Source: NYS Early Intervention Program*								
Year>	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Infants screened	28,215	26,697	27,063	26,578	41,355	156,000	231,123	227,848
Total Births	258,897	257,567	257,748	260,571	258,449	255,529	250,434	236,259
Percent screened	10.9%	10.4%	10.5%	10.2%	16%	61%	92%	96.4%

Tuberculosis: New York State reported a slight increase in the number of tuberculosis cases in 2003 as compared to 2002. The number was still significantly below the number of cases in 2001 when 1676 cases of tuberculosis were reported. Statewide in 2003, 1,480 cases were reported, with 1,140 cases in New York City and 340 cases in the rest of the State. That's an 11.7 percent decrease from a total of 1,676 cases in 2001.

In New York City, cases decreased 14.0 percent between 2001 and 2002. In New York State outside of New York City, the 350 cases reported in 2002 represent a 15.7 percent decline compared to the 415 cases in 2001. Approximately half of all the cases outside New York City are from three counties: Nassau, Suffolk, and Westchester, while the remainder of cases is distributed throughout the State, especially in areas with large foreign-born populations. The numbers of cases in 2003 were consistent with 2002 figures.

In a recent report issued by CDC, New York State led the nation in reducing the number of cases reported in 2002 compared to 1992. Over the 11-year period, the number of cases in New York State declined 68.6 percent, a rate of decline over 22 percent better than the next ranking state, among states reporting 500 or more cases annually.

Childhood Immunization Levels and Vaccine Preventable Diseases: Childhood immunization has had a major effect on reducing and eliminating some important causes of illness and death among children. Monitoring immunization levels is one of the key strategies that will increase immunization rates in under-immunized populations, and helps the Department to evaluate current public health strategies to increase immunization rates.

There has been very little change in incidence of vaccine-preventable illness between 1999 and 2001, with the exception of Hepatitis B. The increase in Hepatitis B cases was primarily among New York City residents. Between 1999 and 2000, the number of cases in NYC increased by 254 to a total of 529. In 2001 and 2002 NYC reported 673 and 727 cases of Hepatitis B. In 2003, however, this trend was reversed when 204 cases of hepatitis B were reported in NYC. The rate was reduced statewide to 1.6 per 100,000 population. Between 2002 and 2003 there was a significant increase in the number of pertussis cases reported. It is likely that the increases in reported cases of pertussis are because of waning immunity in the adolescent population and greater availability of testing.

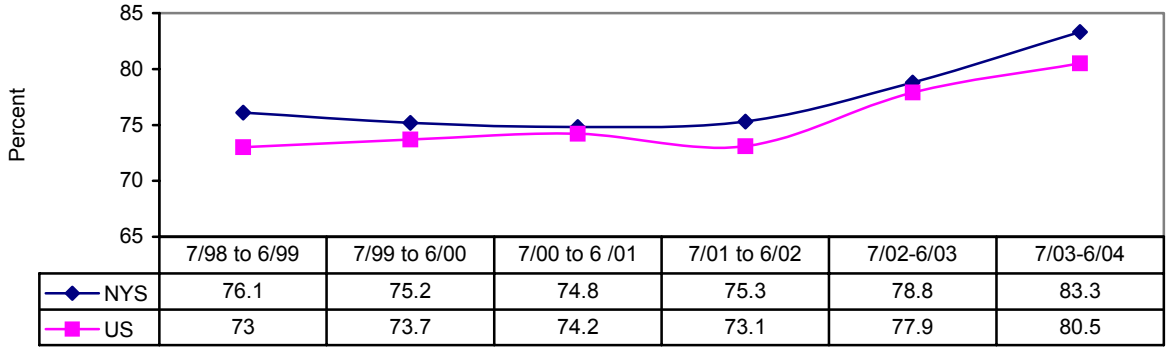
Table 9. **Cases of Vaccine-Preventable Disease 1996-2003**

Year	1998		1999		2000		2001		2002		2003	
Disease	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***	**Cases**	**Rate***
Hepatitis B	651	3.5	496	2.7	710	3.9	827	4.4	867	4.6	314	1.6
HiB**	131	0.7	18	0.1	174	1.0	157	0.8	205	1.1	222	1.2
Measles	4	---	2	---	10	0.1	4	0.0	91	---	7	.04
Mumps	157	0.8	0	---	12	0.1	4	0.0	7	---	15	0.1
Pertussis	364	2.0	1020	5.5	385	2.1	175	1.6	447	2.4	1217	6.4

***Rate is per 100,000**
****Hemophilus inflenza* B**

Childhood Immunization: New York has surpassed the healthy People 2010 goal of 80% for childhood immunization. After declining from July 1998 – June of 2001 rates have improved for the past three years to a high of 83.3 percent of kids ages 19-35 that are fully immunized. New York State's rates have been consistently higher than the immunization rates nationally.

Figure 21. **Vaccination Coverage with 4:3:1:3:3* Among Children**
Ages 19-35 Months, New York State
Source: National Immunization Survey



	7/98 to 6/99	7/99 to 6/00	7/00 to 6 /01	7/01 to 6/02	7/02-6/03	7/03-6/04
NYS	76.1	75.2	74.8	75.3	78.8	83.3
US	73	73.7	74.2	73.1	77.9	80.5

*4:3:1:3:3 -Four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB.

Immunization Levels by 24 months of Age US, New York State, New York City, Rest of State July 2003 through June 2004 *Source: National Immunization Survey*				
Vaccination Level	**US**	**New York State**	**New York City**	**Rest of State**
4:3:1	83.1 +/-0.8	86.2 +/-3.4	82.1 +/-5.5	89.8 +/-4.2
4:3:1:3	82.3 +/-0.9	85.6 +/-3.5	81.2 +/-5.6	89.4 +/-4.2
4:3:1:3:3	80.5 +/-0.9	83.3 +/-3.7	77.5 +/-6.2	88.5 +/-4.3
4:3:1:3:3:1	74.5 +/-0.9	79.4 +/-4.0	74.6 +/-6.4	83.6 +/-5.0
4:3:1	4 DTP,3 poliovirus vaccine, and 1 of any MCV			
4:3:1:3	4 DTP, 3 poliovirus vaccine, 1 of any MCV, and 3 Hib			
4:3:1:3:3	4 DTP, 3 poliovirus vaccine, 1of any MCV,3 Hib, and 3 HepB			
4:3:1:3:3:1	4 DTP, 3 poliovirus vaccine, 1 of any MCV, 3 Hib, 3 HepB,1varicella			

The National Immunization Survey reports on the percent of children immunized at several different levels. Fully immunized is considered 4:3:1:3:3. In areas of New York outside of New York City, 88.5 percent of children were fully immunized at 24 months of age. This compares to 77.5 percent for New York City and 80.5 percent for the nation as a whole. When looking at those that are fully immunized and have also had a dose of the varicella vaccine (4:3:1:3:3:1) the percent of children immunized in the state drops to 79.4 percent. This is still higher than the national percentage of 74.5. Within those parts of New York outside New York City, the rate is slightly higher at 83.6 percent.

Onset of Sexual Activity: There is a relationship between age of sexual initiation, number of partners, frequency of sexual activity, history of sexual abuse, and a myriad of other risk factors particular to adolescents.

In New York State, the 2003 Youth Risk Behavior Survey (YRBS) found the percentage of teens that have experienced sexual intercourse increases with age, from 31.7% of ninth graders to 62.2% of 12th graders. Although these numbers are cause for great concern, they are comparable to the national average of 34.4% of ninth graders and 60.5% of 12th graders. Of New York students responding, 7.1% reported having had sexual intercourse for the first time before the age of 13, compared to seven percent nationally; 29.7% of New York State high school students describe themselves as currently sexually active, compared to 33% nationally.

Contraceptive Use: There is often a significant period of time between initiation of sexual intercourse and the choice and utilization of an effective method of contraception. According to the 2003 YRBS:

- The percentage of New York teens reporting condom use during their last sexual intercourse was 70.4, up from 62% on the 1999 survey. Nationally, the rate was 58%.
- New York State adolescent males reported higher use of condoms during their last sexual intercourse than do adolescent females – 77.1% of adolescent males (compared to 67.9% in 1999) and 64.0% of adolescent females (compared to 56.3% in the 1999 survey) reported using condoms during their last intercourse. Nationally, 65.5% of adolescent males and 51.3% of adolescent females reported condom use on last intercourse.
- Condom use among sexually active teens increased from 1997, when 73.3% of New York males and 62.2% of New York females reported condom use.
- In New York State, 15.2% of high school students (compared to 18.2% nationally) reported using birth control pills during their last sexual intercourse.
- 25.6% of the adolescent males responding to the survey and 17.4% of adolescent females who responded reported alcohol or drug use at last sexual intercourse. Nationally the figures

were 31% and 21%, respectively. Use of alcohol is generally associated with reduced inhibitions and has a negative statistical correlation with effective use of contraceptives. These data for the 1999 survey were at levels of 24.7% for males and 22.4% for females.

Sexually Transmitted Diseases and HIV: Unprotected, high-risk sexual behavior places individuals at risk for sexually transmitted diseases and HIV. If undiagnosed and untreated, there can be lifelong consequences, including infertility and death. In 2004, there were 173 cases of early stage syphilis in Upstate New York State. This is an increase from 114 cases in 2003, 71 cases in 2002 and 40 cases in 2001. Males accounted for 85% of cases in 2004 and are responsible for the increasing trend in occurrence. The highest rates were in among men, ages 20 to 39.

There were 7,714 reported cases of gonorrhea in Upstate New York State in 2004. This was down from 8,484 cases in 2003. Females accounted for 53% of the cases. Females between the ages of 15 and 19 had the highest incidence rates (400.8 per 100,000) among all age groups. This high rate, however, is an improvement over the 2003 rate of 465.5 among females 15-19.

Early Syphilis* Age-Specific Rates by Year and Sex (excluding New York City) New York State – 2000 to 2004

	Total Cases	Age 10-14	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60+
2000												
Male	25	--	--	0.9	1.9	0.5	1.8	0.9	0.5	--	--	--
Female	10	--	--	0.9	0.6	0.8	0.4	--	--	--	--	--
2001												
Male	31	--	0.5	1.5	1.6	1.6	1.3	0.7	0.5	0.3	0.4	--
Female	9	--	--	0.6	--	0.5	0.9	0.2	--	--	--	--
2002												
Male	50	--	0.3	2.1	2.3	2.6	1.8	1.5	1.8	0.6	0.4	--
Female	21	--	1.1	1.9	1.3	0.3	0.9	0.2	--	0.3	--	--
2003												
Male	91	--	0.5	4.4	1.9	4.5	4.0	3.7	1.5	1.4	1.1	--
Female	23	--	0.8	0.9	3.2	1	0.4	--	0.2	--	--	--
2004												
Male	148	0.2	1.3	5.9	4.5	6.6	7.3	5.2	2.8	2.8	1.8	
Female	25	0.3	0.3	0.9	0.6	1.0	0.9	0.7	0.5	0.8	0.7	

Gonorrhea Age-Specific Incidence Rates by Year and Sex (excluding New York City) New York State – 2000 to 2004

	Total Cases	Age 10-14	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60+
2000												
Male	3814	5.3	187.1	353.7	228.1	117.5	73.0	36.3	23.3	16.4	10.3	7.2
Female	4631	37.1	498.8	466.7	185.2	74.4	39.6	16.3	8.2	2.7	0.3	--
2001												
Male	4481	5.8	230.9	409.6	273.9	131.2	75.5	45.0	33.0	18.6	16.2	8.6
Female	5201	46.4	568.6	524.3	216.2	73.6	37.6	19.1	6.1	2.7	2.1	0.4
2002												
Male	4392	6.1	220.2	392.5	261.9	136.8	74.1	50.5	33.3	21.2	13.3	5.8
Female	4725	40.4	501.3	473.6	193.9	82.8	36.1	19.5	7.3	2.4	1.4	--
2003												
Male	3962	4.6	182.5	351.9	230.3	128.1	79.2	50.7	28.8	21.5	8.5	7.2
Female	4522	35.8	465.5	439.9	198.1	79.1	36.8	25.2	9.9	3.5	1.7	1.3
2004												
Male	3619	3.6	162.8	304.0	219.9	101.3	69.7	54.2	38.8	17.5	15.1	8.6
Female	4095	26.5	400.8	399.6	193.9	78.1	34.6	20.8	10.9	6.2	3.1	0.9

** Any of the first three stages of syphilis (primary, secondary or latent of less than one year's duration) are termed early syphilis.*
Source: NYSDOH Bureau of Sexually Transmitted Diseases

Chlamydia cases have been increasing since data collection began in 2000. In 2004, 24,718 cases were reported in Upstate NY. The numbers of cases have been increasing for both males and females; 74 percent of reported cases are among females.

Chlamydia Age-Specific Rates by Year and Sex (excluding New York City) New York State – 2000 to 2004

	Total Cases	Age 10-14	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60+
2000												
Male	1054	1.5	68.2	115.6	62.7	25.1	11.5	5.5	3.5	0.6	1.1	---
Female	4263	30.4	501.8	454.4	154.5	51.0	21.1	9.5	5.6	1.6	2.1	0.4
2001												
Male	3569	5.6	235.0	414.3	190.4	79.1	34.6	20.1	9.8	5.9	3.7	3.8
Female	13180	75.0	1523.3	1482.4	481.8	160.8	60.6	24.5	10.2	4.8	2.7	0.4
2002												
Male	4039	6.6	272.2	472.6	211.8	93.1	33.1	21.9	9.5	4.5	4.4	1.0
Female	14046	89.1	1641.4	1535.3	522.5	161.6	66.0	26.5	12.9	6.7	3.1	2.2
2003												
Male	5437	3.9	327.3	629.4	321.3	122.8	55.9	35.0	16.0	9.9	3.7	3.4
Female	16417	97.1	1884.8	1851.9	614.3	197.0	70.1	31.2	14.8	5.4	4.5	2.2
2004												
Male	6315	8.3	387.8	732.7	361.6	134.2	55.9	38.7	22.0	10.4	6.3	2.9
Female	18403	101.8	2078.1	2059.9	720.0	210.0	76.5	37.1	23.5	10.0	5.8	3.0

As of December 2003, children under the age of 13 made up 1.5% of New York's AIDS cases, while adolescents age 13-19 made up 0.5%. Approximately 51% of these cases were males and 49% were female. Of those diagnosed in the young adult age group, a significant portion likely contracted the disease in adolescence. In 1993, 88% of the students responding to the Youth Risk Behavior Survey stated that they had ever been taught about HIV or AIDS. On the 2001 YRBS, that percentage had increased to 91%, but on the 2003 YRBS was again at 88%.

Other Youth Risk Behavior: The 2003 Youth Risk Behavior Survey offers a great deal of information about high school students across the State. A summary of these data follows:

Risk for Unintentional Injuries- According to the survey, more than four out of five (81%) students who rode bicycles in the past 12 months reported they never or rarely wore a bike helmet. Students at highest risk were older (87% of seniors vs. 78% for ninth graders), and New York City students were less likely to wear helmets than those in the rest of the State.

12% reported on the survey that they never or rarely wore seatbelts when in a car driven by someone else. 23% reported this behavior in 1997.

21.1% of the high school students responding reported they rode in a car with someone who had been drinking alcohol. 7.8% reported they had driven a car or other vehicle when drinking alcohol; males were more likely to report doing so than females (9.7% vs. 5.8%).

Motor Vehicle Crashes- Statistics compiled by the New York State Department of Motor Vehicles and the Governor's Traffic Safety Commission showed a continued decline in the rate of fatal crashes. The data, compiled by the Traffic Safety Management and Research, which showed a rate of 1.1 deaths per 100 million vehicle miles traveled is the safest year since 1920, when records began. In 2002, there were 1,390 fatal crashes and 1,509 deaths on New York's roads. In 2003, there were 1,351 fatal crashes and 1,477 people killed on New York's roadways. Raymond P. Martinez, Commissioner for the New York State Department of Motor Vehicles, attributes the low rates to public education and enforcement of the state's stringent traffic laws.

The study also found:

- The 2003 rate of 13 deaths per 100,000 licensed drivers to mark the safest year on record.
- The rate of deaths per 100,000 population was 7.7.
- Vehicle occupant fatalities were down more than 4.2% from 2002.
- The number of fatal crashes in New York State has declined by over 50% in the past three decades.

Risk for Intentional Injuries- Males in New York were more than three times as likely to carry a weapon to school than females (21% vs. 6.0%).

5.9% of students responding to the YRBS reported that they had missed school because they felt unsafe at school or on the way to school, females at the rate of 6% and males at the rate of 5%.

7.2% of students reported being threatened or injured with a weapon while on school property. More males were threatened than females (10% vs. 5%). Ninth graders were more likely to be threatened or injured than seniors (9% vs. 5%).

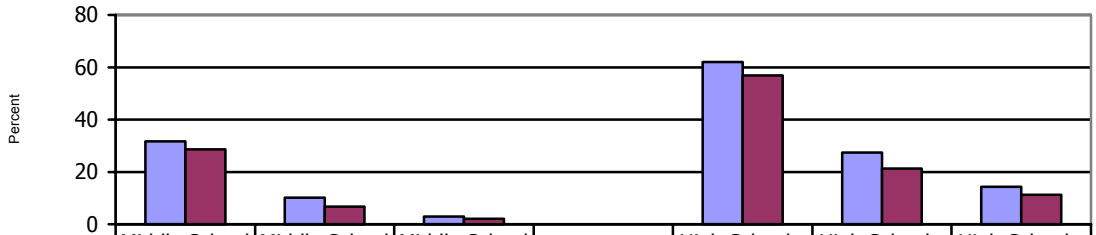
About a third of the students (32%) reported participating in a physical fight. Ninth graders were again more likely to report this behavior than seniors (38% vs. 25%). 7.5% of students reported being slapped or being physically hurt by a boyfriend or girlfriend. 6.7% of females and 4.3% of males reported being forced to have sexual intercourse when it was not wanted.

28% (almost a third) of students reported feeling sad or hopeless almost every day for 2 weeks or more. The rate for females (34.3%) was higher than for males (21.3%). 14.4% of students seriously considered attempting suicide. Females were more likely to have considered this than males (19.6% vs. 9.3%). 10.9% of students actually made a plan for how they would attempt suicide. Almost 7% reported attempting suicide one or more times. Females attempted at a rate twice that of males (10% vs. 4%). 2% needed medical care.

Youth Tobacco Use- The Youth Tobacco Survey (YTS) is administered in New York State on a biannual basis to students in sixth through twelfth grades. The YTS estimates tobacco use, exposure to environmental tobacco smoke, knowledge and attitudes about tobacco, access to tobacco products by minors, counter-marketing and tobacco cessation in middle and high school students. The results of the 2000 and 2002 YTS show important declines in youth tobacco use. In New York State middle school students, current use of tobacco declined from 10.1% in 2000 to 6.7% in 2002. High school students had a decline in current use (from 27.4% to 21.6%), frequent use (from 14.3% to 11.2%) and ever use (62.0% to 56.9%).

Middle & High School Ever, Current, & Frequent Use of Cigarettes

Source: NYS Youth Tobacco Survey, 2000 and 2002



	Middle School - Ever Use	Middle School - Current Use	Middle School - Frequent		High School - Ever Use	High School - Current Use	High School - Frequent Use
2000	31.7	10.1	2.9		62	27.4	14.3
2002	28.6	6.7	2.1		56.9	21.3	11.2

The Youth Behavioral Risk Survey (YRBS) also queries students about smoking. 51.2% of students participating in the Youth Risk Behavior Survey in New York in 2003 reported they had tried smoking, compared to 65.9% in 2001. 16% reported smoking a whole cigarette before the age of 13. 20% reported smoking one or more cigarettes in the last 30 days. 9% smoke cigarettes on 20 of the last 30 days. 13% smoked two or more cigarettes on the days they smoked. 21% of students under age 18 reported they were able to purchase cigarettes. 13% of males and 4% of females reported smoking cigars, cigarillos, or little cigars.

Youth Alcohol and Substance Use- Of respondents to the 2003 YRBS, 72.2% of all students had at least one drink of alcohol on one or more days of their lives; 27% had their first drink before age 13. In 2001, those data were at 83.4% and 30%, respectively. 44.2% of 2003 respondents had at least one drink of alcohol in the last 30 days, compared to 54% on the 2001 survey. 27% of males and 23% of females reported they had five or more drinks of alcohol in a row on one or more days in the last 30 days.

The use of drugs other than alcohol was consistently higher for males than for females. The 2003 survey found:

- 37.1% of students reported they had tried marijuana, compared to 46.7% in 2001;
- 21% used marijuana one or more times in the last 30 days, compared to 26.7% in 2001;
- 6.1% of students reported using cocaine, compared to 8.3% in 2001;
- 10.1% of students reported they had sniffed glue or breathed the contents of aerosol cans to get high, compared to 14.7% in 2001;
- 4.7% reported using methamphetamines, compared to 7.7% in 2001;
- 1.8% reported using heroin, compared to 3.8% in 2001; and
- 4.3% of males and 2.3% of females reported the use of steroid pills or shots without a doctor's prescription, compared to 7.2% and 3.7%, respectively in 2001.

According to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA) there were 13,826 substance abuse treatment admissions in 2001 and 15,017 in 2002 among youth aged 12 - 17 in New York State. 26% of these were related to marijuana use.

Sudden Infant Death Syndrome: The table below illustrates the relationship between occurrence of SIDS deaths as a subset of total infant and post-neonatal deaths. The table also contains PRAMS Survey responses indicating mothers who reported putting their infants to sleep on their backs. It is widely believed that changing infant sleep position to have them sleep on their backs only has greatly reduced the SIDS rate from 0.8 per 100,000 population in 1995 to 0.3 per 100,000 in 2003.

Table 11. **Proportion of Post-Neonatal Deaths that Are SIDS, % Moms Reporting Back-to-Sleep 1995 - 2002**

Year	1996	1997	1998	1999	2000	2001	2002	2003
All deaths < 1 Year	1829	1728	1607	1571	1436	1450	1489	1450
Post-neonatal deaths	570	520	467	478	443	447	436	458
SIDS deaths	146	118	100	74	74	74	57	50
% SIDS of Post-Neonatal Deaths	25.6%	22.6%	21.4%	15.5%	16.7%	16.6%	13.1%	10.9
% PRAMS Moms responding that they put their infants on their back to sleep	34.5%	45.2%	53.0%	56.7%	63.4%	68.0%	65.8%	DNA*

*DNA = Data Not Available.

Leading Causes of Death: The leading causes of death for children, birth to 19 years in 2003 for New York State, New York City, and the rest of the state are reflected on the table that follows.

The figures show:

- More than half of the infant deaths in the state are caused by conditions arising in the perinatal period.
- Among children aged 1-9, unintentional injury is the most likely cause of death in both New York City (39.7%) and New York State-excluding NYC (30.6%). In both regions homicide and legal intervention remains in the top five causes of death for this age group.
- Unintentional injuries are the leading cause of death among children ages 10 to 19 years in New York State – excluding New York City (43.9%), but in New York City, the category of homicide and legal intervention is the leading cause of death (23.7%).
- Suicide is the third leading cause of death among New York State 10- to 19-year-olds. Suicide accounts for 7.7% of deaths in this age group, and when New York City is excluded, it represents 8.5% of deaths in the rest of the state. The lower death rate in New York City may be reflective of better access to mental health services and emergency care.

Homicide and Major Crime/New York City: The New York City Police Department reported that the 2004 homicide rate in New York City showed a decline of 70.3% since 1993. Overall, major crime in New York City, including robbery and assault, was down approximately 67% in the same time period.

LEADING CAUSES OF DEATH, 2003
FOR CHILDREN BIRTH TO AGE 19 YEARS

New York State Children

All Ages			Under Age 1		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	155,015	100.0	All Causes	1,518	100.0
Diseases of the heart	55,255	35.6	Cond Orig in Perinatal Period	887	58.4
Malignant Neoplasms	36,060	23.3	Congenital Anomalies	275	18.1
Cerebrovascular disease	7,219	4.7	SIDS	50	3.3
CLRD	6,704	4.3	Unintentional Injuries	23	1.5
Pneumonia	5,416	3.5	Diseases of the Heart	22	1.4
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	377	100.0	All Causes	801	100.0
Unintentional Injuries	89	23.6	Unintentional Injuries	267	33.3
Malignant Neoplasms	57	15.3	Homicide & Legal Intervention	126	15.7
Congenital Anomolies	34	9.0	Suicide	62	7.7
Diseases of the Heart	31	8.2	Malignant Neoplasms	60	7.5
Homicide and legal intervention	24	6.4	Diseases of the Heart	28	3.5

New York State – Exclusive of New York City

All Ages			Under Age 1		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	97,098	100.0	All Causes	778	100.0
Diseases of the Heart	31,515	32.5	Cond Orig in Perinatal Period	430	55.3
Malignant Neoplasms	23,160	23.9	Congenital Anomalies	152	19.5
Cerebrovascular disease	5,350	5.5	SIDS	25	3.2
CLRD	4,996	5.1	Unintentional Injuries	15	1.9
Unintentional Injuries	3,006	3.1	Diseases of the Heart	11	1.4
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	209	100.0	All Causes	481	100.0
Unintentional Injuries	64	30.6	Unintentional Injuries	211	43.9
Malignant Neoplasms	34	16.3	Homicide & Legal Intervention	50	10.4
Congenital Anomalies	19	9.1	Suicide	41	8.5
Diseases of the Heart	13	6.2	Malignant Neoplasms	38	7.9
Homicide and legal intervention	12	5.7	Diseases of the Heart	14	2.9

New York City

All Ages			Under Age 1		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	57917	100.0	All Causes	740	100.0
Diseases of the Heart	23740	41.0	Cond Orig in Perinatal Period	457	61.8
Malignant Neoplasms	12900	22.3	Congenital Anomalies	123	16.6
Pneumonia	2670	4.6	SIDS	25	3.4
Diabetes Melitus	1870	3.2	Diseases of the Heart	11	1.5
Cerebrovascular disease	1869	3.2	Homicide & Legal Intervention	10	1.4
Ages 1 – 9 Years			**Ages 10 – 19 Years**		
Cause	**Number**	**Percent**	**Cause**	**Number**	**Percent**
All Causes	163	100.0	All Causes	320	100.0
Unintentional Injuries	25	39.7	Homicide & Legal Intervention	76	23.7
Malignant Neoplasms	23	14.1	Unintentional Injuries	56	17.5
Diseases of the Heart	18	11.0	Malignant Neoplasms	22	6.9
Congenital Anomalies	12	7.4	Suicide	21	6.6
Homicide & Legal Intervention	12	7.4	AIDS	14	4.4

AIDS Deaths: Though the number of Annual AIDS deaths has declined dramatically over the period of the last 5 years, New York remains an epi-center for AIDS with more than 18% of the total U.S. AIDS cases. As of December 31, 2003, the rate of AIDS deaths per 100,000 was 9.9, compared to 6.2 nationally. The number of persons who are HIV-infected in the State is estimated at 150,000. As of December 2003, there were 35,304 presumed living, HIV-only (not AIDS) cases confirmed and reported in New York State since the beginning of HIV reporting in June 2000.

The breakdown of cumulative reported CDC-defined AIDS cases in the State compared to the US was as follows:

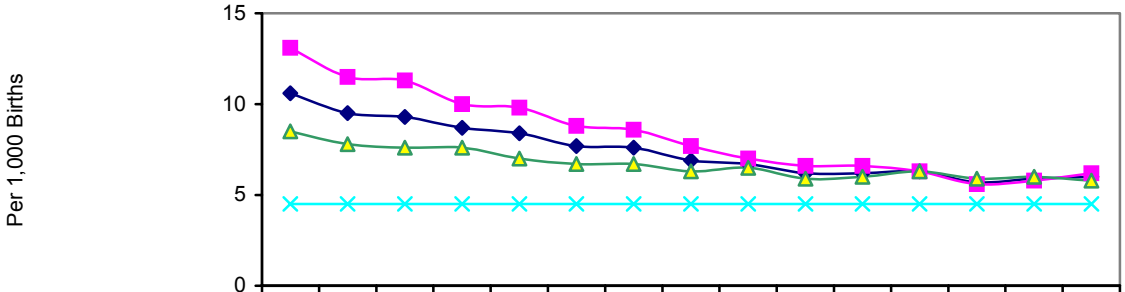
Table 12. **Cumulative AIDS Cases Reported Through December 31, 2003**
New York State Data - Includes State Prison Inmates
Source: NYS Data From Data Set As Of 1/4/05

AIDS Cases	Total	Male	Female	White	Black	Hispanic	Asian/Pacific Islander	Native American	Other/ Unknown
US	902,223	81.4%	18.6%	40.9%	39.3%	18.5%	0.8%	0.3%	0.2%
NYS**	157,034	75.0%	25.0%	26.2%	43.6%	29.2%	0.7%	0.1%	0.2%

**In 2004 the Center for Disease Control and Prevention (CDC) completed the Interstate Duplication Evaluation Project (IDEP) in which all states were required to participate. The purpose of the project was to identify duplicate cases of HIV/AIDS that have been reported to the National HIV/AIDS Surveillance System by two or more states and to assure that the cases are only counted once. If a case was reported by two or more states, the earliest data of diagnosis was used to determine to which state the case was assigned. CDC estimates that 30,000 of the AIDS cases in the national surveillance system were duplicates, representing less than 5% of the almost 1 million cases that have been reported to CDC over the history of the epidemic through 2002. It is anticipated that this process will be conducted on an ongoing basis. The percent of AIDS cases that were lost in NYS due to this process was approximately 3%. Please note that this loss of AIDS cases will most likely not affect New York's Ryan White funding or other funding based on AIDS count. This is because New York's estimated 3% loss in AIDS cases compares favorably with the average loss of cases for the nation, which was a little less than 5%.

Infant Mortality: The infant mortality rate has declined by approximately 32% since 1991. For the first time in 1996, New York's infant mortality rate was below the Healthy People 2000 goal of 7.0 per 1000 births. In 1997 and 1998, the decline continued and infant mortality reached an all time low of 6.2 per 1000. Since 1998, however, the rate has leveled off. In 1999, for the first time in ten years, the infant mortality rate did not decline and remained at 6.2 per 1,000 births. In 2000, the rate increased slightly to 6.3 per 1000. This was due to a small increase in the rest of State rate (6.0 to 6.3). In 2001 the rate again started to decline. The 2001 rate of 5.7 is the lowest NYS rate ever recorded. The rate increased slightly in 2002 to 5.9 per 1,000. In 2003, the rate again increased slightly to 6.0 per 1,000. During 2003, Upstate experienced a small decline (6.0 to 5.8) while the New York City rate increased slightly (5.8 to 6.2). The Healthy People 2010 goal is 4.5 per 1000 live births. Efforts to reduce infant mortality must continue and be reinforced in order to meet the Healthy People 2010 goal for the nation.

Figure 22. **Infant Mortality Rate**
New York State, New York City and Rest of State 1989 - 2003



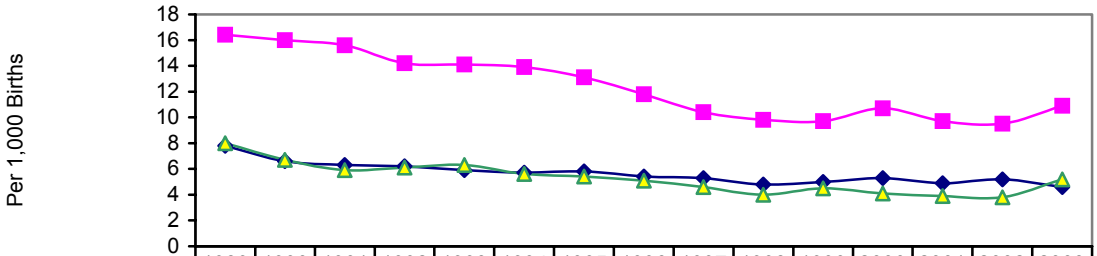
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	10.6	9.5	9.3	8.7	8.4	7.7	7.6	6.9	6.7	6.2	6.2	6.3	5.7	5.9	6
New York City	13.1	11.5	11.3	10	9.8	8.8	8.6	7.7	7	6.6	6.6	6.3	5.6	5.8	6.2
Rest of State	8.5	7.8	7.6	7.6	7	6.7	6.7	6.3	6.5	5.9	6	6.3	5.9	6	5.8
HP 2010 Goal	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5

New York City Department of Health Office of Vital Records tracks infant mortality on a neighborhood basis, but since the rates are based on relatively small numbers of infant deaths, they are subject to year-to-year fluctuations, which may represent random variations, and not significant trends. From these data, infants born in the neighborhood with the highest infant mortality rate, namely Fort Greene with a rate of 10.6 infant deaths per 1,000 live births, are nearly four times as likely to die in their first year than infants from the neighborhood with the lowest rate, Maspeth-Forest Hills with a rate of 2.7 deaths per 1,000 live births. The New York City infant mortality rate is based on a total of 839 deaths out of 125,563 live births.

In a statewide analysis of infant deaths over the three years from 2000 to 2002, the counties with the lowest infant mortality rates were Putnam (2.2), Schoharie (2.2) and Saratoga and Fulton (3.3). Rates were highest in Hamilton (14.7), Chenango (9.9) and Onondaga (9.7).

There is a racial and ethnic disparity in infant mortality rates. In 2003, infant mortality increased slightly in the Black (9.5 to 10.9) and Hispanic (3.8 to 5.2) populations and declined among whites (5.2 to 4.6). The change was partly due to changes in the coding of "race/ethnicity" data. Hispanics have continued to experience lower rates than blacks, but now are experiencing rates slightly higher than the white population. At 5.8 per 1,000 the rate for the Hispanic population no longer meets the Healthy People 2010 goal of 4.5 per 1,000 live births.

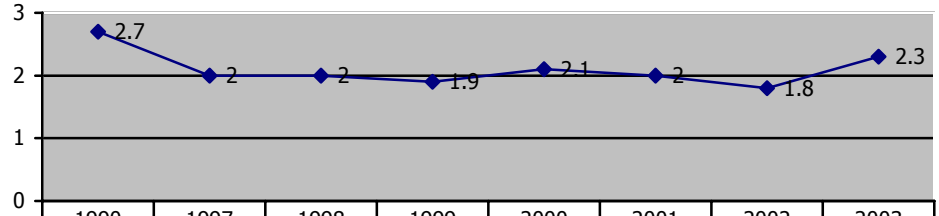
Figure 23. **Infant Mortality Rate**
New York State Residents by Race 1989 - 2003



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	7.8	6.6	6.3	6.2	5.9	5.7	5.8	5.4	5.3	4.8	5	5.3	4.9	5.2	4.6
Black	16.4	16	15.6	14.2	14.1	13.9	13.1	11.8	10.4	9.8	9.7	10.7	9.7	9.5	10.9
Hispanic	8	6.7	5.9	6.1	6.3	5.6	5.4	5.1	4.6	4	4.5	4.1	3.9	3.8	5.2

The Black/White ratio for infant mortality peaked in 1990 at 2.7, based on rates of 16.0 and 6.0, then declined slightly between 1991 and 1997, when it fell to 2.0. It remained at 2.0 in 1998, when the white infant mortality rate was 4.8 per 1000 and the Black rate was 9.8 per 1000. It again dropped slightly to 1.9 in 1999. In 2000 the rate was 2.1 when both white and black mortality rates increased slightly to 5.3 and 10.7 per 1000 respectively. The ratio dropped to 2.0 in 2001 when rates for Blacks and Whites were 9.7 and 4.9, respectively, and 1.8 in 2002 with rates of 5.2 and 9.5, respectively. In 2003, the ratio was increased again to 2.3 based on rates of 10.9 and 4.6.

Ratio of Black to White Infant Mortality
1990, 1997 - 2003
Source: Based on Vital Records Data

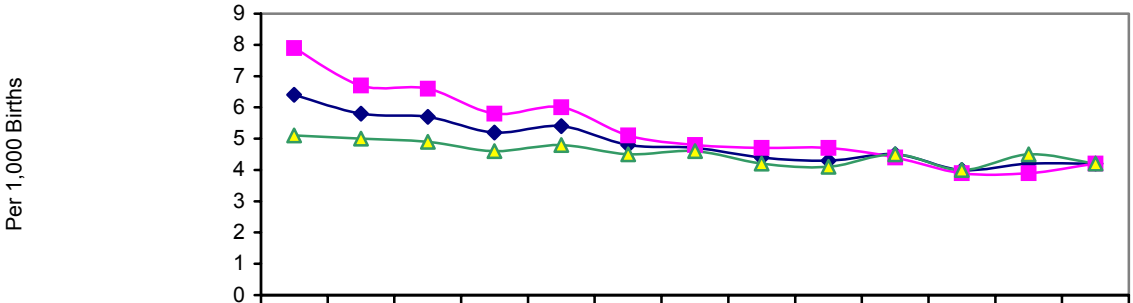


	1990	1997	1998	1999	2000	2001	2002	2003
B:W Ratio	2.7	2	2	1.9	2.1	2	1.8	2.3

Neonatal Mortality: Trends in neonatal mortality mimic those of infant mortality. Between 1991 and 2001 neonatal mortality declined 33% to 3.9 per 1000 births. Similar to infant mortality, the declines have leveled off in recent years and the rate increased slightly between 1999 and 2000. The increase was due entirely to an increase in the Rest of State rate from 4.1 in 1999 to 4.5 in 2000. For the first time ever, New York City residents experienced slightly lower neonatal mortality rates as compared to the rest of the state. The New York City rate dropped from 4.7 in 1999 to and all time low of 4.4 in 2000. In 2001, the Neonatal death rate again declined to an all time low of 4.0 per 1000 live births. Declines were seen in both NYC and rest of state with NYC again reporting a slightly lower rate (3.9) than the rest of the state (4.0). In 2002, the rate rose slightly to 4.2 per 1000. All of the increase was seen in the rest of state

while NYC's rate remained the same. In 2003, the New York State rate was 4.2 per 1,000. The rate was the same (4.2 per 1,000) for New York City and the Rest of State. This, as was seen with infant mortality, represents a slight increase for NYC and a slight decrease for the rest of state.

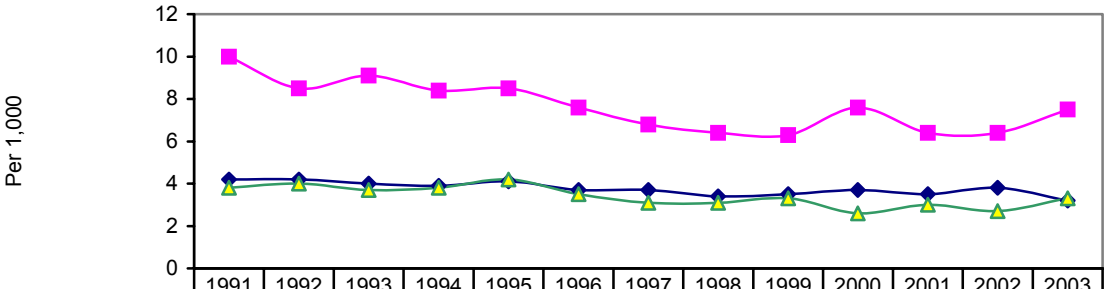
Figure 24. **Neonatal Mortality Rate**
New York State Residents by Region 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	6.4	5.8	5.7	5.2	5.4	4.8	4.7	4.4	4.3	4.5	4	4.2	4.2
New York City	7.9	6.7	6.6	5.8	6	5.1	4.8	4.7	4.7	4.4	3.9	3.9	4.2
Rest of State	5.1	5	4.9	4.6	4.8	4.5	4.6	4.2	4.1	4.5	4	4.5	4.2

There is a significantly higher neonatal mortality rate among Black births. In 2001, the Black neonatal death rate was 6.4 per 1000 births, almost double the rate for Whites (3.5 per 1000) and slightly lower than the 2000 rate of 7.6 per 1000. This disparity, while still significant, has been improving. In 1991, the Black/White ratio was 2.3. In 1998 and 1999, it was 1.8. In 2000, however the ratio went to 2.1 when the black rate increased more than the white rate. In 2001 the ratio was 1.8. Hispanics continued to experience the lowest neonatal death rates in New York State. The 2001 rate for Hispanics was 3.0 per 1000 births, up slightly from 2.6 per 1000 in 2000. The 2002 the White neonatal death rate was up slightly to 3.8 per 1,000 live births, while the Black rate remained the same as in 2001. The Black to White ratio was 1.7. Among Hispanics, the rate declined to 2.7 per 1,000 live births. In 2003, the White rate was lower than in 2002, while the Black and Hispanic rates were higher. Again, coding changes are responsible for some of the changes in the rates, so it is difficult to compare to past years. The 2003 black/white ratio for neonatal mortality was 2.3.

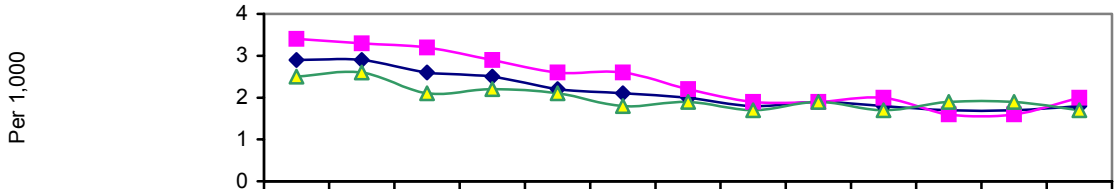
Table 24a. Neonatal Mortality Rate
NYS Residents by Race 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	4.2	4.2	4	3.9	4.1	3.7	3.7	3.4	3.5	3.7	3.5	3.8	3.2
Black	10	8.5	9.1	8.4	8.5	7.6	6.8	6.4	6.3	7.6	6.4	6.4	7.5
Hispanic	3.8	4	3.7	3.8	4.2	3.5	3.1	3.1	3.3	2.6	3	2.7	3.3

Post-Neonatal Mortality Rate: The post-neonatal mortality rate in New York State has also declined significantly. Between 1991 and 2003, it declined 37.9% to 1.8 per 1000 live births. Declines have been seen in both New York City and the rest of the State. In 1999, there was no difference in the rates for the two areas. Between 1999 and 2000 the rest of State rate dropped slightly to 1.7 while the New York City rose at 2.0 per 1000. In 2001 the statewide rate dropped to 1.7. The entire decline was seen in NYC where the rate went to 1.6 in 2001 and from 2.0 in 2000. The rest of the state rate rose slightly to 1.9 per 1000. In 2002 the rates remained at 2001 levels for all areas. In 2003, there was a slight increase in the rate from 1.7 to 1.8 per 1,000 live births. This was a result of an increase in the New York City rate (1.6 to 2.0) and a decrease in the Rest of State rate (1.9 to 1.7).

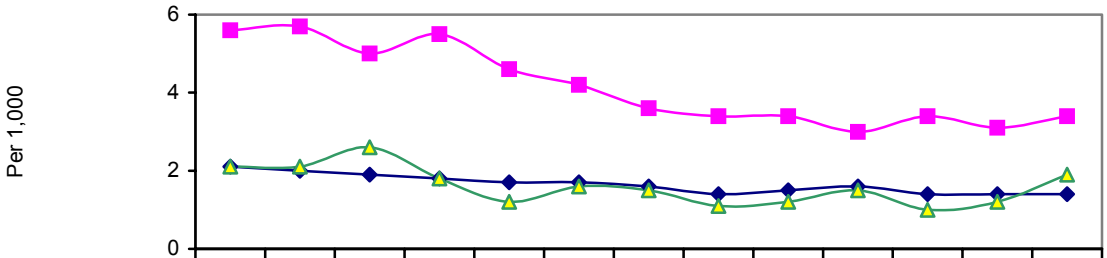
Figure 25. **Post-Neonatal Mortality**
New York State Residents by Region 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
New York State	2.9	2.9	2.6	2.5	2.2	2.1	2	1.8	1.9	1.8	1.7	1.7	1.8
New York City	3.4	3.3	3.2	2.9	2.6	2.6	2.2	1.9	1.9	2	1.6	1.6	2
Rest of State	2.5	2.6	2.1	2.2	2.1	1.8	1.9	1.7	1.9	1.7	1.9	1.9	1.7

The disparities in rates between Blacks and Whites that were seen in both infant and neonatal mortality rates are also seen here in post-neonatal mortality. Between 2002 and 2003, the difference in the rates increased when the Black rate increased and the White rate remained the same. Based on post-neonatal death rates of 1.4 per 1000 among whites and 3.4 per 1000 among blacks, the Black/White ratio in 2003 was 2.4.

Figure 26. **Post-Neonatal Mortality Rate**
New York State Resident by Race 1991 - 2003



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	2.1	2	1.9	1.8	1.7	1.7	1.6	1.4	1.5	1.6	1.4	1.4	1.4
Black	5.6	5.7	5	5.5	4.6	4.2	3.6	3.4	3.4	3	3.4	3.1	3.4
Hispanic	2.1	2.1	2.6	1.8	1.2	1.6	1.5	1.1	1.2	1.5	1	1.2	1.9

C. Children with Special Health Care Needs

New York applauds national efforts to establish data for numbers of children with special health care needs. As a State Health Department, we are working to improve what is known about special needs children in our State in order to better serve them and better serve their families.

The Children with Special Health Care Needs data system Phase 1 is now fully implemented in 53 counties. New York City and the other four local health units are expected to be online after Phase 2. Phase 2 expands data available and simplifies retrieval. Data have been reported from 53 out of 58 local health units on 6,565 children identified with special health care needs. Last year at this time there were 5,820 children being served.

Early identification of children with special health care needs is evident, with a significant proportion of children referred between their birth and four years of age (26%). The largest group referred is children 10 to 14 year olds (30%), representing the large number of families seeking assistance with medically necessary orthodontia. Five- to nine-year-olds represents 19% of the referrals and fifteen- to nineteen-year-olds represents 22%. Three percent of the referrals are for children 20 to 21 years of age. The emphasis of the program at this age is on transitioning young adults from the pediatric setting to adult health care and social support systems.

Data from the local health units indicate that, of the children referred to the CSHCN Programs, 75.5% in 1999, 74.2% in 2000 and 61.0% in 2001 have primary health care providers. Data are collected only on admission. The drop is felt to be related to increasing success with enrollment of children with special health care needs in Medicaid and Child Health Plus. Once enrolled in CSHCN Program and insurance, families find it easier to enroll in primary care.

The major sources of referrals for the Children with Special Health Care Needs Program are:

- hospitals or specialty providers (42%);
- followed by parents/family (23%);
- the Physically Handicapped Children's Program (14%);
- the Early Intervention Program (5%); and
- primary health care providers (4%).

The racial background of the children referred was reported as white (62%), African-American (5%), other (2%), Asian (1%) and no response (30%). These percentages of those served are roughly proportional with Upstate demographics.

Consistent with the large number of adolescents referred to the program, orthodontia represents the most common diagnosis, accounting for 32% of the children referred. Ear disorders are second at 16%; followed by nervous system disorders (6%), musculoskeletal disorders (5%), apnea/prematurity (4%), diabetes (4%), disorders of the respiratory system (3%), congenital anomalies (3%), and heart disorders (3%). Other diagnoses representing less than 2% each include neoplasms; cleft lip/palate; late effects injury; and GU, blood, endocrine, circulatory, skin, thyroid metabolic, eye, digestive and mental disorders.

Insurance coverage is determined at the time of referral. Program data indicated insurance status of those served as follows: 88% have insurance, 8% are uninsured, and for 4% insurance status is unknown. Of those with insurance, 47% request assistance for services not covered by their benefit package, 37% need assistance with co-payments, 14% with paying premiums, 13% have exceeded their annual and/or lifetime benefits and 12% need assistance with deductibles.

SLAITS Study: The Maternal and Child Health Bureau at HRSA identified six core outcomes for measuring States' progress toward implementing family-centered, community-based, comprehensive, coordinated, easily accessible system for Children with Special Health Care Needs. MCHB also developed a monitoring strategy utilizing a national telephone survey conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) called SLAITS – State and Local Area Integrated Telephone Survey.

From the SLAITS, New York learned that:

- An estimated 60.3% ± 4.5% of New York families of children with special health care needs were partners in decision-making and were satisfied with the services they are receiving.

- An estimated 51.7% ± 2.4% of New York families of children with special health care needs were obtaining care within a medical home.
  - About 92% reported a usual source of care.
  - About 90% had a personal doctor or nurse.
  - About 76% said they had no problem receiving needed referrals.
  - About 46% reported receiving effective care coordination when needed.
  - About 67% said their care was usually family centered.

- An estimated 59.1% ± 2.3% of New York families of children with special health care needs had adequate insurance coverage to pay for the services they need.
  - About 96% had public or private insurance at the time of the interview.
  - About 89% had no gaps in coverage in the year prior to the interview.
  - About 83% had insurance that always or usually met the child's needs.
  - About 72% found costs not covered by insurance was usually or always reasonable.
  - About 85% said insurance usually or always permitted the child to see needed providers.

- Approximately 75.3% ± 3.8% of families said systems were organized in a way that families can use them easily.

- Relative to transition of children with special health care needs to adulthood, an estimated 61.5% ± 7.1% said their doctors had spoken to them about their changing needs as they become an adult. Approximately 48.4% ± 11.5% have a plan for transition to adult services and 32.6% ± 9.5% said their doctor had discussed shifting to an adult provider. Approximately 35.7% ± 7.8% received vocational or career training.

The results of the SLAITS study for New York are documented on **Form 11. National Performance Measures 2 through 6.**

In 2004, NYSDOH, with assistance from the CDC, drafted an analysis plan for the use of 2001 National Survey of Children with Special Health Care Needs (CSHCN) New York State data. The purpose is to assess the prevalence, characteristics, and health care experiences of CSHCN and their families in the State, to examine health care insurance status of CSHCN, to identify barriers to insurance for CSHCN, and to assess the quality of medical homes for CSHCN in the State. The research questions are to compare outcomes with national and other state outcomes, to determine how well CSHCN are insured, and to determine the status of medical homes for CSHCN in the State.

Kernicterus: New York has begun tracking kernicterus cases following concern expressed by consumers that this condition may be on the increase nationwide. The SPARCS data file, which

tracks hospital discharges, and the death files were examined. The diagnosis was tracked for appearance as a primary diagnosis, or as an "other-than-primary" diagnosis. The findings appear in the table below. Further analysis is warranted to determine the extent of this problem.

Hospital Discharges for Kernicterus - All ages *Source:* ***2003 SPARCS Date***			
Diagnostic Category	**Total # of Cases**	**New York City**	**Rest of State**
774.7 Kernicterus not due to isoimmunization	1 Primary 18 Other	0 Primary 14 Other	1 Primary 3 Other
773.4 Kernicterus due to isoimmunization	1	1 Other	0
Hospital Discharges for Kernicterus - Age One Year and Younger - *Source:* ***2003 SPARCS Date***			
Diagnostic Category	**Total # of Cases**	**New York City**	**Rest of State**
774.7 Kernicterus not due to isoimmunization	1 Primary 18 Other	0 Primary 15 Other	1 Primary 3 Other
773.4 Kernicterus due to isoimmunization	1	1 Other	0
Hospital Discharges for Kernicterus - Age up to 8 weeks - *Source:* ***2003 SPARCS Date***			
Diagnostic Category	**Total # of Cases**	**New York City**	**Rest of State**
774.7 Kernicterus not due to isoimmunization	1 Primary 17 Other	0 Primary 15 Other	1 Primary 2 Other
773.4 Kernicterus due to isoimmunization	1	1 Other	0
Deaths due to Kernicterus *Source:* ***2000-2002 Death Certificates***			
ICD 10 Codes P57.0, P57.8, P57.9	0	0	0

Fetal Alcohol Syndrome Surveillance: Fetal Alcohol Syndrome or FAS is a preventable birth defect caused by maternal alcohol drinking during pregnancy. The syndrome is diagnosed by using a combination of findings, which may include poor growth, central nervous system disorders, certain FAS-related facial features, and a history of maternal alcohol use during pregnancy. The syndrome may be more difficult to recognize in newborns, but easier to diagnose in older children. New York has two systems to ascertain Fetal Alcohol Syndrome cases: the statewide birth defects registry and FASSNet, or the Fetal Alcohol Syndrome Surveillance Network. FASSNet is a population-based, multi-source system where records of children with FAS or known or suspected prenatal exposure to alcohol are actively enrolled and their records abstracted. In a recent study comparing the accuracy of FAS reports to the registry with the FASSNet system, FASSNet was shown to identify more children than the registry alone.

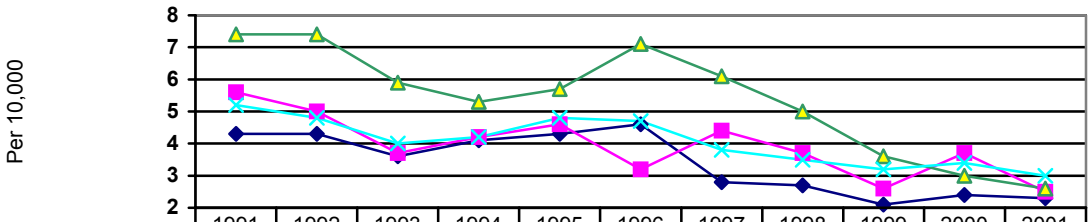
From 1996 through 2003, New York was a part of the National Birth Defects Prevention Study, a CDC-funded collaborative. For this study, a random sample of women who gave birth from 1997 to 2003, whose children did not have a major structural malformation were controls. The study area was an 8-county region in Western New York. Women were interviewed within two years of childbirth. The study questionnaire asked about alcohol intake before and during pregnancy. In the three months before conceiving, 50% of the women reported any drinking (95% CI 41-59%), and 15.2% reported at least one episode of binge drinking (95% CI 9.4 to 22.7%). In the first three months of pregnancy, 8% reported at least one episode of binge drinking (95% CI 4.0 to 14.1%). Past studies have shown that drinking during pregnancy tends to be under-reported. Also, while most women reduce or stop drinking once they know they are pregnant, pre-pregnant levels of alcohol consumption may continue in the earliest stages of pregnancy until the woman realizes or is told she is pregnant.

In the project area, the 1995-1999 birth cohort had an incidence of FAS of 0.72 per 1,000. Rates were higher in urban Buffalo, where there was an overall rate of 1.92 per 1,000. The non-Hispanic white rate was 0.83 /1,000; the rate for African Americans was 3.4/1,000.

Neural Tube Defects: The table that follows shows the trend in incidence of neural tube defects to be declining. The source of these data is the New York State Congenital

Malformations Registry. Please note: The Black and White categories do not include Hispanics in the calculation. Information is reportable to this registry for up to two years from the date of birth. Therefore, later figures are not available. This rate is affected by rates of pregnancy termination based on the information provided by prenatal testing.

Figure 27. **Rate of Neural Tube Defects per 10,000 Live Births**
New York State 1991 - 2001*



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
White	4.3	4.3	3.6	4.1	4.3	4.6	2.8	2.7	2.1	2.4	2.3
Black	5.6	5	3.7	4.2	4.6	3.2	4.4	3.7	2.6	3.7	2.5
Hispanic	7.4	7.4	5.9	5.3	5.7	7.1	6.1	5	3.6	3	2.6
Total*	5.2	4.8	4	4.2	4.8	4.7	3.8	3.5	3.2	3.4	3

*Including unknown race

Please refer to Table 5 for information from the NYS PRAMS on mothers' knowledge of folic acid to prevent neural tube defects.

Cleft Lip and Palate: During 1998-2001, 1061 children in this state, at a rate of 10.4 per 10,000 live births, were born with cleft lip, palate or both. New York has an effective mechanism for identifying, recording, and referring these infants for treatment. Cleft lip and palate are eligible conditions under the Physically Handicapped Children's Program (PHCP) and the Dental Rehabilitation component of PHCP.

4. MCH Capacity by Pyramid Level

Overall Capacity: The State Title V Agency in New York State remains the **New York State Department of Health (NYSDOH)**. Responsibility for the administration of Title V is vested with the Division of Family Health. To understand capacity relative to direct medical, enabling, population-based and infrastructure services, it is first helpful to understand NYSDOH's capacity as a state agency.

The New York State Department of Health has as its mission: *"Working together and committed to excellence, we protect and promote the health of New Yorkers through prevention, science and the assurance of quality health care delivery."* Our organizational vision is that of "*a community of professionals who, through commitment to education, innovation, leadership, customer respect and research solutions for health problems, make New Yorkers the healthiest people in the nation."* We seek to carry out our mission through a core set of values, which includes: *dedication to public good, innovation, excellence, integrity, teamwork,* and *efficiency.*

NYSDOH is an executive agency, with Commissioner Antonia C. Novello, M.D., M.P.H., Dr.P.H., reporting directly to Governor George E. Pataki. As a former U.S. Surgeon General, and as a pediatrician and former Special Representative to UNICEF, Dr. Novello has a solid record of leadership and commitment to maternal and child health. She has many times over demonstrated her capacity to promote and protect the health of all mothers, infants and children, including those with special health care needs. Early in her tenure, she met with the MCHSBG Advisory Council and discussed her plans for the Department and her appreciation for the advice of the Council. She continues on a daily basis to provide the leadership needed to effectively address New York's multiple and complicated health issues.

Maternal and child health programs are located throughout the New York State Department of Health, but are mostly located in the **Center for Community Health** and the **Division of Family Health**, where administrative oversight for the Block Grant is vested.

In addition to its responsibility for Title V, the **Division of Family Health** is responsible for family planning (Title X), early intervention (Part C) services, the Prenatal Care Assistance Program, perinatal networks, designation of perinatal centers and CSHCN specialty centers, dental health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention, universal newborn hearing screening and programs for children with special health care needs. This division is located within the **Center for Community Health**. The State Health Department's organizational chart is included with this submission under **Appendix C.** (*Figures 3 and 4)*. Organizational structure and staffing support our mission, vision and values.

There are currently 218 filled Title V-funded positions within the NYSDOH and an additional 630 non-Title V-funded positions performing Title V-related activities. Positions are located within the Department's central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women's health, perinatal health, dental health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance.

The Center for Community Health

Guthrie Birkhead, M.D., M.P.H., is the Director of the **Center for Community Health.** Dr. Birkhead was appointed Director of the Center for Community Health in January 2001 and has been Director of the AIDS Institute since December 1995. Prior to that Dr. Birkhead worked in

the field of communicable disease epidemiology and control for 11 years. He is a graduate of the CDC Epidemic Intelligence Service program and the CDC Preventive Medicine Residency Program. He joined the New York State Health Department in 1988 and became the Director of the Bureau of Communicable Disease Control in 1993. He is board certified in internal medicine and preventive medicine, and holds a Masters of Public Health Degree. He is Associate Professor of Epidemiology at the School of Public Health at the University at Albany, founding Director of the Department's Preventive Medicine Residency Program, and Past President of the Council of State and Territorial Epidemiologists.

Executive Deputy Director of the Center for Community Health is Ms. Ellen Anderson. Ms. Anderson comes to the Center after having served as co-director of the Office of Managed Care. She has an extensive administrative background. Ms. Phyllis Silver is Special Assistant. Ms. Silver also came to the Center from the Office of Managed Care. Prior to that time, she was the Department's Advocate for Children, and in that title had responsibility for Title V activities. She has an extensive background in early childhood issues and maternal and child health.

The **Office of Local Health Services** is located within the Center for Community Health and directed by Ms. Sylvia Pirani. This unit is the touch point for communication and coordination with the 58 local health units. This unit ensures that the State is working in partnership with local health departments and other health care providers to strengthen core public health functions as changes are occurring in health care financing and delivery systems. Working closely with local health units, the Department is able to promote and ensure essential maternal and child health services that complement those provided by managed care and the private sector. Ms. Marie Miller is deputy director and oversees State Aid to local health units, the completion of community health assessments and municipal public health services plans.

Information and data needs related to Title V activities are met through the Center for Community Health's **Public Health Information Group (PHIG)**. Directed by Mr. Michael Medvesky, PHIG provides data access and technical assistance to central office, regional offices and local county health departments. The Public Health Information Group provides services such as preparing data for the Title V needs assessment and developing MCH data sets. This unit also has responsibility for the **Pregnancy Risk Assessment Monitoring Survey (PRAMS)**. Partially supported by a grant from the Centers for Disease Control and Prevention, they seek to improve capacity for data management and for targeting and designing successful public health interventions at a state and local level. Ms. Anne Radigan is the PRAMS Project Director.

Mr. Medvesky has over 25 years of experience in public health, epidemiology, research methods and evaluation. He advises on public health indicators for many health initiatives in addition to the Block Grant, and is very knowledgeable about community and local assessment methods, sources of data, and improvement of data capacity. He currently serves as the project manager of New York's CDC-funded Cooperative Agreement to Support State Assessment Initiatives.

PHIG is also responsible for the New York State **Community Health Data Set**, which consists of a series of tables, maps and graphs containing health statistics organized by county of residence. Because it resides on the Health Information Network, it is readily available for use by counties in compiling their community health assessment. The Community Health Data Set includes information from natality and mortality data from the birth, death and fetal death files; from SPARCS (a data set containing information on all hospital discharges in the state); from the Department of Health's disease registries, and from program-based systems. The Community Health Data Set is organized in nineteen sections, and offers mortality data as both crude rates and age-adjusted rates.

The **Office of Minority Health,** directed by Ms. Wilma Waithe, promotes the health of the State's minority populations by leading, coordinating, supporting and assessing the Department's efforts to reduce and, ultimately, eliminate health disparities. This Office works with Title V in facilitating community awareness of MCH services, and helping to assure access, appropriateness and acceptability of services. Central to the Office's activities are: the Minority Health Community Partnerships, grant program, which mobilizes communities to eliminate health disparities through coalition-driven, asset-based, neighborhood-specific interventions; and the Minority Health Mini-Grants Program, which supports short-term, small-scale projects which build capacity of community-based organizations to provide culturally- and linguistically- appropriate services, and improve outreach to minority populations.

Fiscal expertise for preparation of the MCHSBG application is provided by Ms. Karen Ousterhout of the **Center for Community Health** and by the **Division of Family Health Fiscal Unit**, directed by Ms. Deborah Nance. Ms. Ousterhout provides the Division of Family Health with fiscal analyses of block grant spending, while contract management is handled by Ms. Nance and the Fiscal Unit. It is important to note that New York externally appropriates half of its block grant dollars to support MCH services at the local and statewide level. In the Division of Family Health alone, approximately 600 contracts are administered annually.

The Division of Family Health

The **Division of Family Health** continues to be responsible for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. This Division contains four bureaus: the **Bureau of Child and Adolescent Health**, the **Bureau of Women's Health**, the **Bureau of Dental Health** and the **Bureau of Early Intervention Services**.

The mission statement of the Division states that, *"[a] s members of the public health community, the Division promotes the health of New Yorkers and supports family empowerment to create healthy communities. With a primary focus on the health needs of women and children, our efforts involve the promotion of healthy behaviors, assurance of quality and accessible health care and adherence to state of the art knowledge and best practices. In partnership with other Departmental units, state agencies and county health departments, we work collaboratively with provider organizations, professional associations, advocacy groups and community coalitions to achieve these goals."*

The values of the Division of Family Health are outlined in this statement: *"Division staff work with integrity, efficiency and professionalism. Vigilantly anticipating future challenges, we remain dedicated to the public good and committed to family-centered care. Innovation is encouraged and teamwork is rewarded. The tasks of accomplishing the Division goals are conducted with compassion and tempered with good humor."*

Ms. Barbara McTague was appointed Director of the Division of Family Health in June 2005. Since 1987, Ms. McTague has implemented and managed a variety of programs with in the Department of Health, and in 1991, she was appointed Director of the Bureau of Women's Health. More recently, she served as Director of the Bureau of Early Intervention Services. Ms. McTague's experience in the AIDS Institute and with various programs and bureaus within the Division of Family Health has given her a very broad understanding of health and development issues impacting women, children and families. Ms. McTague has overall responsibility for policy, direction and oversight for the Division of Family Health and its bureaus and programs.

Dennis Murphy, M.A., is Associate Director of the Division of Family Health. Mr. Murphy received a BA in Education and a Masters degree in Political Science/Public Administration from the University of New York at Buffalo. He has extensive experience in public health and epidemiology, particularly in working with local health departments and health provider agencies.

He directed New York State's STD Control Program of a number of years. Mr. Murphy provides administrative oversight for each of the Divisions bureaus.

Within the Director's office, Michelle Cravetz, M.S., R.N.-B.C., coordinates MCHSBG-related activities, grant submission, grant management activities and special projects. Ms. Cravetz has 30 years of maternal and child health experience at the local, regional and State level. She served as MCH Consultant Nurse, Regional Director of Preventive Health Services, Clinical Consultant to the Migrant and Indian Health Programs, Director of the School Health Program, and Director of the Office of Rural Health and Primary Care. Ms. Cravetz is Principal Investigator (PI) to the State Systems Development Initiative and family and consumer forums. She is a member of the Department's Institutional Review Board for the Protection of Human Subjects and serves on the University at Albany's Continuing Education in Public Health Advisory Panel. Ms. Cravetz was appointed Assistant Director of the Bureau of Dental Health in January 2003.

Christopher Kus, M.D., M.P.H., also serves within the office of the Director as the Pediatric Consultant for the Division of Family Health. He is a developmental pediatrician who has worked with the New Hampshire and Vermont Departments of Health prior to coming to New York. He has been with the New York State Department of Health for the past ten years. He serves as a liaison with the State Medicaid Program and the Office of Managed Care. Dr. Kus is Past President of the Association of Maternal Child Health Programs (AMCHP). He has chaired their committee on Service Delivery and Financing Systems and co-chaired the MCH-Medicaid Technical Advisory Group.

Thomas Carter, Ph.D., continues to coordinate the cross-systems, cross-agency partnerships for the Department. Dr. Carter also coordinates the MCH Graduate Assistant Program, which matches priority MCH projects with graduate assistants from the School of Public Health at the University at Albany, and directs the Migrant Health Program.

Patricia Waniewski, M.S., R.N. is the Asthma Coordinator as part of a five-year grant with the Centers for Disease Control. As such, Ms. Waniewski coordinates the various asthma initiatives across the Department and is instrumental in implementing our New York State Asthma Plan.

Rose Pandozy is a former local Department of Social Services Commissioner and comes to the Division from the Office of Medicaid Management. She is working within the Division as Director of the American Indian Health Program. Ms. Pandozy works with the Native American nations across the state to provide access to primary care and services.

The Division of Family Health is also administrative home to New York's **State Systems Development Initiative (SSDI)** grant, coordinated by Ms. Cathy Tucci-Catalfamo. The goal of SSDI grant is to ensure meaningful measurement of attainment of Block Grant Performance Measures. To this end, Ms. Tucci-Catalfamo has been working the Title V Coordinator and program staff to develop the Children with Special Health Care Needs Data System and in gathering parent and consumer input to this grant's needs assessment. In 2004, SSDI worked with the Integrated Child Health Information System (ICHIS) and assist Title V with data matching and data infrastructure issues.

The Division of Family Health has four bureaus: the Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Women's Health, and the Bureau of Early Intervention Services.

The Bureau of Child and Adolescent Health

The mission of the **Bureau of Child and Adolescent Health** (BCAH) is to promote and protect the health and well being of New York's infants, children and youth through:

- Defining the parameters of optimal health for children, birth through 21 years of age, throughout New York State;
- Assessing current status of children's health in New York State;
- Conducting Needs Assessments to obtain and maintain optimal health and to identify resources and gaps in resources;
- Identifying/developing/implementing strategies to address the disparity between existing health status and optimal health status and to maintain optimal health; and
- Providing ongoing monitoring and evaluation of efficiency and effectiveness of strategies employed.

Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Lead Poisoning Prevention, Pediatric Asthma, Healthy Child Care New York, Children with Special Health Care Needs, the Physically Handicapped Children's Program, Youth Development, the School Health Program, the School Health Infrastructure Initiative, ACT for Youth, Abstinence Education, the Community-Based Adolescent Pregnancy Prevention Program, Innovative Pediatric Services, Infant and Child Mortality Review, Interim Lead-Safe Housing Program, the Regional Lead Poisoning Technical Assistance Centers, and the Gay, Lesbian, Bisexual and Trans-gendered Health Initiative. BCAH also has responsibility for the Early Childhood Comprehensive Systems Initiative.

The Bureau Director for the **Bureau of Child and Adolescent Health** (BCAH) is Rachel de Long, M.D., M.P.H. She was appointed in May 2005. Dr. de Long is a graduate of the Preventive Medicine Residency Program at the University at Albany. She had served as Acting Director of the Bureau and Coordinator of the Early Childhood Comprehensive Systems Planning Initiative. Ms. Marta Riser, Associate Director of this Bureau, continues her active leadership role in activities related to adolescent services, assets building and risk reduction activities. She has also been very involved in putting together the State's **Adolescent Health Agenda** and the **ACT for Youth** initiative.

The Bureau has five units and one initiative: the School Health Unit; the Medical Home Unit; the Adolescent Health Unit, the Childhood Lead Poisoning Prevention Unit; the Child Morbidity and Mortality Prevention Unit and the Early Childhood Comprehensive Systems Planning Initiative.

The **School Health Unit** is headed by Annette Johnson and contains the following programs: School Based Health Centers, Comprehensive Coordinated School Health, and School Health Infrastructure.

The **School Health Program** is the largest school-based primary care program in the US, with over 180 school-based health center sites. Sites offer comprehensive, accessible services to children from preschool age through high school in high-risk urban, suburban and rural communities. The program has undergone recent expansions in the areas of dental and mental health services. The **Coordinated School Health** representative is Laurie Ann Zavarelli at the State Health Department and Patricia Kocialski at the State Education Department. This is a collaborative initiative promotes comprehensive health and wellness in the school setting.

The **Childhood Lead Poisoning Prevention Unit** provides prevention, early detection and effective treatment of childhood lead poisoning. A collaborative relationship exists between this program, the Center for Environmental Health's housing and community efforts, and Wadsworth Laboratories' efforts in lead testing and tracking. The unit funds **Regional Lead Resource Centers,** where county health departments and providers may receive technical assistance; **Lead Poisoning Prevention Coalitions;** and **Interim Lead-Safe Housing.** They are also responsible for the **Statewide Lead Elimination Plan**.

The **Medical Home Unit** is directed by Susan Slade, MS, RN. This unit has responsibility for the **Children with Special Health Care Needs Program**, the **Physically Handicapped Children's Program**, **Asthma Coalitions,** and the **Medical Home Resource Centers**. The **Childhood Asthma Program** supports seven regional asthma coalitions and public and provider education. The coordinator works closely with the Division's Asthma Coordinator. The new **Champions for Progress** grant is also housed in this unit.

Healthy Children New York, originally funded as a **Community Integrated Service Systems (CISS)** grant, is coordinated by Ms. Mary Huber, working closely with the Office of Children and Family Services (childcare licensors) to improve the health and safety of children in childcare. The program has educated over 100 individuals in the Northeast, Central, Western, Lower Hudson Valley, Long Island, and Capital Regions of the State, and is planning classes in New York City this fall.

The **Children with Special Health Care Needs (CSHCN) Program** provides services to children, ages birth to 21, that are not provided through Medicaid or SSI Medicaid. The CSHCN Program also certifies specialty centers to promote access to comprehensive evaluation and treatment services for those children in whom a serious, chronic illness or physical disability is suspected. Recently, the program strengthened their ability to identify, report and act on identified needs for the CSHCN population and their families by launching a new data system for the use of the 58 local health department-based Children with Special Health Care Needs Programs. Additional changes are underway to bring the CSHCN data system into compatibility with the Early Intervention Program data system.

The Title V program employs five **parents of children with special health care needs**, one of whom, Ruth Walden, is officially employed as **Family Specialist** and a parent advocate. (The others are employed as public health program nurses, health program administrator and SSDI Coordinator.) The parents help link our agency to parent groups like Family Voices, Parent-to-Parent, Mothers United for Moral Support (MUMS) and other statewide parent advocacy agencies. Employing parents and using parent input has improved our focus on comprehensive, family-centered, community-based, culturally competent, coordinated care. Title V parents are also working with the various stakeholders statewide to formulate the parent training that will take place under the new Champions for Progress initiative.

The role of the Family Specialist, our official "Title V Parent", is to maintain communication and linkages with families of Children with Special Health Care Needs. She provides support, exchanges information between parents and the Department, gets input on program actions, reviews and evaluates information from families and professionals, and determines possible course of action that may improve service delivery systems. Typically, her activities include organizing training programs, advising intra- and inter-agency groups on policies related to children with special health care needs, public speaking and assisting in the development of grant proposals that reflect the parent perspectives. As New York's Title V parent, Ms. Walden has taught several parents, both within and outside our State, to be Block Grant reviewers and is frequently called upon by others to provide training in parent involvement or to review other States' grants. Ms. Walden is often called upon by the Maternal Child Health Bureau to provide family feedback regarding Children with Special Health Care Needs. Ms. Walden has also served as the Family Voices Coordinator for New York State and on the Emergency Medical Services for Children advisory panel.

The **Adolescent Health Unit** is directed by Ms. Kristine Mesler. The programs in this unit include ACT for Youth, the Community-Based Adolescent Pregnancy Prevention Program, Abstinence Education and the Lesbian, Gay, Bisexual, Transgender Health Project. Ms. Mesler also serves as New York's **Adolescent Health Coordinator.**

The **Abstinence Education Program** seeks to reduce the teen pregnancy and birth rates, as well as to reduce the proportion of adolescents who have engaged in sexual intercourse in target communities and the incidence of sexually transmitted diseases in teens in the targeted communities.

The **Community-Based Adolescent Pregnancy Prevention** also uses a targeted community approach to reduce adolescent pregnancy rates. The program provides community information and education to sensitize the public about the local need to address the prevention of unintended pregnancy. The program also promotes use of peer educators to reach adolescents at risk of unintended pregnancy. Peer educators provide factual information, identify social pressures and responses to these pressures and teach assertiveness skills. They also work with peers parents, schools, community health and human service organizations, local governments, businesses and the media. Youth development activities, including educational, recreational and vocational opportunities designed to improve self-esteem, are also provided.

The **Childhood Morbidity and Mortality Unit** is directed by James Raucci. This unit is responsible for Childhood Death Review, morbidity and mortality surveillance, SIDS prevention and response, and the Enhance Pediatric Services Initiative.

The **Early Childhood Comprehensive Systems Planning Initiative** had been directed by Dr. de Long, and is now to be directed by Tammy Nazarko, who is moving to BCAH from the Bureau of Women's Health, where she served as statewide Women's Health Coordinator.

The Bureau of Women's Health

Dr. Barbara Brustman is the Director of the Bureau of Women's Health, Ms. Wendy Shaw as Assistant Director, and Mary Applegate, M.D., M.P.H., serves as that bureau's medical director. The Bureau of Women's Health has responsibility for the Department's perinatal, family planning, maternal mortality review, breastfeeding and rape crisis programs, and works with other units throughout the Department to coordinate initiatives related to women's health. The Bureau of Women's Health also has responsibility for the **"Growing Up Healthy Hotline"**. Dr. Applegate leads the **Preventive Medicine Residency Program.** The Bureau is the liaison with **Healthy Start.**

The mission of the Bureau of Women's Health is to promote the health of women across their reproductive life span through the development, implementation and coordination of women's health programs. The Bureau endeavors to promote the health of women of reproductive age, to promote the birth of healthier babies, to ensure the availability of reproductive choices to prevent unintended pregnancies, to reduce adolescent pregnancy, and to reduce violence against women as well as its impact on women, their families and their communities. The Bureau values teamwork, integrity, professionalism, commitment and communication.

The **Family Planning/Reproductive Health Services Unit** is directed by Ms. Joan Linton. The **Family Planning Programs** provide low-income, uninsured and underinsured women with comprehensive reproductive and preventive health services, including routine gynecological exams and laboratory testing; screening for high blood pressure, anemia and diabetes; health education; screening and treatment of sexually transmitted infections; HIV counseling and testing; contraceptive services; preconception planning and counseling; pregnancy testing, and referral to prenatal care. **Infertility services** are also housed within this unit.

Ms. Kathleen Martin directs the **Rape Crisis Program**, which includes the development of programs and provision of services to improve the response to rape and sexual assault.

Ms. Linda Thornton directs the **Perinatal Services Unit** within the Bureau. This unit is responsible for an array of services to improve perinatal, maternal and infant outcomes throughout New York State, including **PCAP** and **MOMS Programs**, the **Community Health Worker Program**, the **Comprehensive Prenatal/Perinatal Services Networks**, **perinatal regionalization**, and the **Statewide Perinatal Data System**.

Ms. Tammy Nazarko has served as the **Comprehensive Women's Health Coordinator**. The Comprehensive Women's Health Initiative served to coordinate across agency programs and across agencies all those efforts related to improving women's health across the lifespan. Under this initiative, a women's heath databook has been formulated and a Women's Health Summit was held.

The Bureau of Dental Health

The Bureau of Dental Health is directed by Elmer Green, D.D.S., M.P.H., and Michelle Cravetz, M.S., R.N.-B.C. is Assistant Director. Jayanth Kumar, D.D.S., M.P.H., serves as Director of Dental Public Health Research. The mission of the Bureau is to improve the oral health of all New Yorkers. The Bureau implements and monitors statewide dental public health initiatives to prevent, control or reduce oral diseases and other health conditions, and promote healthy behaviors, dental sealants, school-based supplemental fluoride and dental rehabilitation programs.

The Dental Bureau provides oversight to 26 **Dental Preventive Services for High-Risk Populations** grantees. Under this program, community-based providers collaborate to provide access to needed dental preventive services, especially for low-income children and pregnant women. More recently, the Bureau funded seven **Innovative Dental Services** grantees, charged with testing new solutions to dental health access issues within their communities. Under this initiative, a statewide **Technical Assistance Center** was also funded at the Rochester Primary Care Network. Both initiatives encourage efficient use of dental resources, community partnerships and collaborations and the establishment of community-based or school-based dental services that will assist individuals to access and obtain needed preventive and primary dental services.

The **Dental Rehabilitation Program** provides medically-necessary orthodontic services to children with physically handicapping malocclusions. In October 2004, the Bureau, in collaboration with the Medicaid Dental Program, extended the pilot of a new method for prior approval to all counties in the state outside of New York City and Long Island. The pilot eliminates the need for regional screening clinics and allows children to be screened for clinical eligibility through clinical documentation of their orthodontic conditions. Treatment services are authorized and approved under the Physically Handicapped Children's Program in participating counties.

The Bureau of Dental Health administers an accredited **Dental Public Health Residency Program.** The Dental Bureau has a grant from the Centers for Disease Control and Prevention to improve surveillance and infrastructure for oral health services in the state.

The Bureau of Early Intervention

The **Bureau of Early Intervention (BEI)** administers the **Part C/IDEA Program** and the **Universal Newborn Hearing Screening Program.** The Bureau is also responsible for the publication of ***"Welcome to Parenthood,"*** which is available in English and Spanish and received by all new mothers delivering their babies in any of New York State's hospitals. Ms. Barbara McTague will continue to direct this Bureau until recruitment of a new director is completed.

The **Early Intervention Program** provides therapeutic and supportive services for children, from birth to age 3, who have developmental disabilities and their families. The program ensures children at risk for disabilities have a "medical home" and receive developmental surveillance and screening from their primary health care provider. Children referred to the Early Intervention Program receive a comprehensive multidisciplinary evaluation to assess the child's cognitive, physical, communication, social/emotional, and adaptive development. Eligible children and their families receive ongoing service coordination services, Individualized Family Services Plans (IFSPs), and Early Intervention services included in their IFSP.

The **Universal Newborn Hearing Screening Program** is within the BEI. Newborn hearing screening program components include: conducting inpatient infant hearing screening prior to discharge from the birth facility; conducting follow-up infant screening or providing referrals to obtain follow-up screening on an outpatient basis for infants who fail or do not receive infant hearing screening prior to discharge; and, referring infants in whom a hearing loss is suspected to the Early Intervention Program for appropriate evaluation and early intervention services.

Other Divisions within the Center for Community Health

Division of Family Health/Title V staff work especially closely with the other Divisions within our Center on MCH-related issues.

Mark Baptiste, Ph.D., directs the **Division of Chronic Disease Prevention and Adult Health.** Assistant Director is Mr. Thomas Blake. Mr. Blake was for many years the Assistant Director in the Bureau of Child and Adolescent Health and is well acquainted with MCH issues. This division has as its mission increasing the years of healthy and independent life for New Yorkers. The division promotes healthy lifestyles; recommends policies for chronic disease prevention in health care, educational, social and other community-based systems; and promotes health and continued independence for those with chronic diseases and disabilities. This division administers several programs that affect the maternal and child population.

Within the Division of Chronic Disease Prevention and Adult Health, their **Bureau of Health Risk Reduction** oversees prevention efforts to reduce tobacco use and change diet and physical activity patterns. This bureau has also been integral to the Department's asthma prevention and control efforts. In addition, this bureau works closely with the Bureau of Child and Adolescent Health on youth tobacco programs. The Bureau is working with the Bureau of Dental Health on a surveillance project. When third graders were screened under the Oral Health Surveillance Project, trained staff also completed height and weight measurements.

The **Bureau of Injury Prevention,** directed by Ms. Susan Hardman, addresses injuries associated with motor vehicles, bicycles, recreation, poisoning, assaults, and suicide. This unit has very strong ties to the Title V program. The primary prevention of violence, particularly intimate violence, is a priority with the Department for the coming years.

The **Division of Nutrition (DON)**, which is directed by Ms. Patricia Hess, administers the **WIC Program**, nutrition services for the homeless and destitute, nutrition training and technical assistance, and the **Child and Adult Care Food Program**. Division of Nutrition collaborates with the Title V programs on issues relating to nutrition assessment and services, nutritional consultation for children with special health care needs and services for hard-to-reach, hard-to-serve individuals. Examples of DON/Title V collaboration include the Monroe County contract consolidation project, childcare health consultation, and joint WIC/Food Stamps/Medicaid/Child Health Plus application. Title V has also collaborated with DON in initiating ***Eat Well, Play Hard***, an intervention to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity. The ***Eat Well, Play Hard*** strategies targeted to children ages 2 and older are: increase the amount of developmentally-

appropriate physical activity; increase consumption of fruits and vegetables; and increase consumption of 1% or less milk and low fat dairy products.

The **Division of Epidemiology (DOE)**, directed by Perry Smith, M.D., State Epidemiologist, is responsible for disease control and disease prevention efforts within the Department. The **Bureau of Sexually Transmitted Disease Control** within DOE collaborates in the Title V funded *chlamydia* screening and treatment program with the Bureau of Women's Health. The **Immunization Program** is located within their **Bureau of Communicable Disease Control**. The Division continues to work with the Title V workgroup on birth outcomes. This Division is also charged with responsibility for new initiatives in HIV reporting and partner notification.

Assistance from Outside the Center for Community Health

The **Bureau of Community Relations** is responsible for coordinating the efforts of state and local governmental units, voluntary agencies, schools, health care facilities and other community resources to address the state's priority health issues. In this role, the bureau provides consultative and technical support services to department program units in designing, implementing and evaluating community-based health communications programs and social marketing strategies to reach target populations. The bureau has expertise in print production and distribution; mass media production and placement; market research and program evaluation; community development; direct marketing; satellite teleconferencing and other distance learning techniques; health education advocacy and training; conference and event planning; and interactive, computer-assisted instruction.

The **Office of Medicaid Management (OMM)** is also within the Department of Health. This has resulted in a close organizational relationship that benefits maternal and child health programs for the Medicaid population. OMM administers the Child/Teen Health Program, New York's EPSDT program. All health plans participating in the Medicaid Managed Care Partnership Plan and Child Health Plus must adhere to Child/Teen Health Program standards. The Department works to ensure the quality of that care through formulation of Medicaid policy, through requirements for statewide certification and through surveillance of facilities and health plans. In addition, the Family Health Plus Program is located within the Office of Medicaid Management.

Since OMM is within the same agency as the Title V program, the **Memorandum of Understanding** in no longer thought necessary. Title V and Medicaid staff drafted a **"Title V/EPSDT Action Plan"** to outline our mutual support for each program. The Action Plan serves as a plan for coordination between the two programs; and states our shared goals for access, availability and quality of health services; and actions each program will take in collaboration with the other. Title V staff worked with the Office of Medicaid Management on an EPSDT provider manual and on improving access to oral health services.

The **Office of Managed Care (OMC)** oversees both commercial and publicly-funded managed care plans throughout the state. OMC works very closely with a variety of maternal and child health programs, including those for children with special health care needs, and with our MCHSBG Advisory Council. OMC was instrumental in assisting the Bureau of Women's Health and Division of Family Health with the incorporation of Prenatal Care and Assistance Program standards into Medicaid Managed Care. OMC staff has also worked with the Bureau of Dental Health on issues related to provider capacity.

The Office of Managed Care has required health plans to coordinate their public health-related activities with the local health units in each of New York's 57 counties and the City of New York. Guidelines were issued that describe required coordination activities for such areas as communicable disease control including tuberculosis, STD, rabies and HIV counseling and testing,

and for maternal and child health programs including childhood lead poisoning prevention. The guidelines encouraged managed care organizations to participate with local health departments in joint community health assessment processes that would identify and address local health problems and gaps in services and to assist in the mobilization of needed services as appropriate.

The **Child Health Plus Program** is administered by the Division of Planning, Policy and Resource Development, which is located outside the Center for Community Health. Title V staff and the MCH Advisory Council have offered policy input. Child Health Plus also actively collaborates with the Title V-funded School Health Program, which is located within the Bureau of Child and Adolescent Health.

The **New York State Charles D. Cook Office of Rural Health (ORH),** operates within the Division of Planning, Policy and Resource Development, under the direct guidance of the Deputy Commissioner for Policy. The ORH provides the Department with guidance on the unique issues faced by rural communities in New York State. ORH coordinates and administers statewide rural health programs, disseminates information and technical assistance to rural providers, and participates in federal and state partnerships to influence rural policy development. ORH implements state-funded programs including the Rural Health Network Development Program and the Rural Health Care Access Development Program, enacted under the New York State Health Care Reform Act. The Office also administers the federally-funded Rural Hospital Flexibility Program, the Small Hospital Improvement Program and the Rural Access to Emergency Devices Program. The office is directed by Ms. Karen Madden.

The **AIDS Institute (AI)**, directed by Dr. Guthrie Birkhead, is responsible for coordinating the State's response to the AIDS epidemic. The AI works with community organizations and governmental agencies to assess need and to ensure a coordinated, coherent, statewide approach to the HIV/AIDS epidemic. Among its responsibilities, the AI monitors and analyzes epidemiological and clinical developments in HIV/AIDS health care and prevention services; plans immediate and long-term objectives for HIV/AIDS health care and prevention services; provides policy advice on HIV/AIDS issues at the local, state and federal levels; develops funding strategies and priorities; administers state and federal funding for HIV/AIDS health care and prevention services; and produces educational materials to reduce the risk of HIV transmission and promote optimal use of health care services.

New York was the first state to develop a comprehensive program of newborn HIV testing in which all mothers and their physicians will be notified if the infant's test result is positive. Under statute, HIV antibody testing was added to the statewide Newborn Screening Program. Expedited testing is also available at time of delivery for those women who are not aware of the HIV status.

The AIDS Institute works with Title V in New York State, and has established coordination and collaboration with Title V staff. AI also participated in a consolidated MCH monitoring pilot with Title V and CCH programs serving the prenatal, postpartum, and birth-to-five population. AI administers monies under Title II of the Ryan White Care Act.

An important collaboration between Title V and the AIDS Institute is the **Community Action for Prenatal Care (CAPC) Program**. This initiative seeks to engage high-risk, pregnant, HIV-positive women in early prenatal care. CAPC is closely coordinated with the Community Health Worker Programs in overlapping regions of New York City and Buffalo.

Title V programs also work in collaboration with programs within our **Center for Environmental Health (CEH)**. CEH provides overall direction for environmental health. CEH

also provides direct environmental services through ten district offices to counties whose local health departments do not provide environmental services.

Within the Center for Environmental Health, the **Bureau of Environmental and Occupational Epidemiology** has responsibility for monitoring adverse reproductive outcomes through the **Congenital Malformations and Chromosome Registries**. The bureau conducts studies evaluating possible causes of these outcomes, and studies related to abatement of leaded housing and environmental exposure to lead.

The **Bureau of Community Sanitation and Food Protection** works closely with MCH migrant health staff for issues related to migrant housing and is the liaison with the Department of Labor for issues related to migrant employment. They also are charged with the responsibility of licensing children's camps and investigating injuries and illnesses associated with camp attendance.

The **Office of Health Systems Management (OHSM)** is the arm of the Department that licenses, monitors and regulates health facilities and agencies. OHSM staff performs facility and home care agency surveys, review and approve plans for new services, and work to improve quality in regulated facilities and agencies. Title V staff interact with OHSM staff on issues relating to standards and quality of care in facilities and agencies that serve the maternal and child population.

The **Emergency Medical Services for Children (EMSC) Program** was administered by the Bureau of Emergency Medical Services in the Office of Health Systems Management. The EMSC Program enhanced emergency medical care for children. Title V representatives regularly attended the EMSC Advisory Committee meetings and provide needed input on the development of EMSC resources benefiting MCH stakeholders. Last year, MCH and EMSC staff worked collaboratively to develop a brochure for families on how to be prepared for emergencies involving their child. It contained a special section for families of children with special health care needs. In addition, a reference card was developed on medical assessment and emergency treatment of technology-assisted children and was distributed to a variety of appropriate partners.

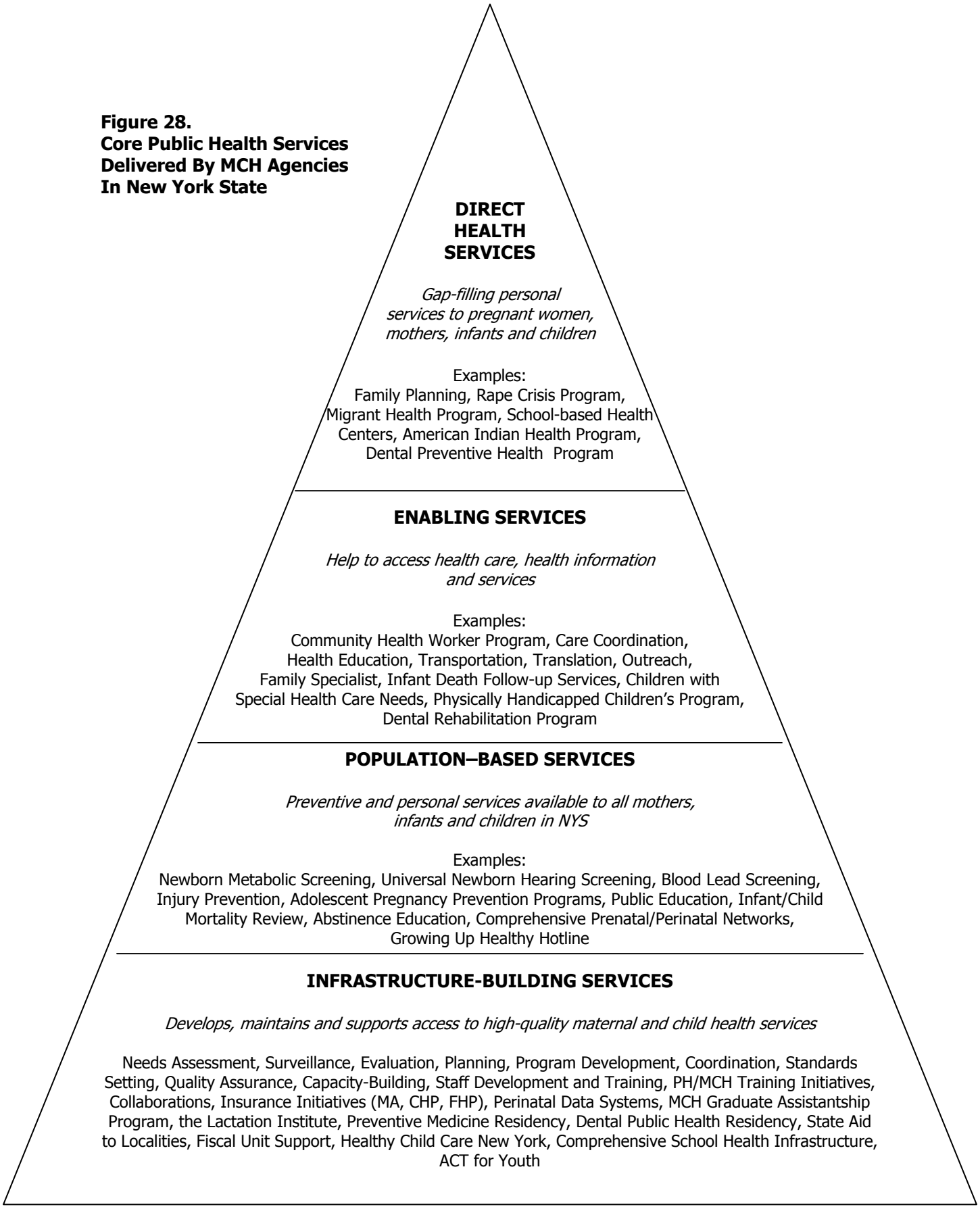
The **Wadsworth Center for Laboratories and Research** is one of the most comprehensive laboratories devoted to public health in existence, providing analytical and diagnostic services, regulation and licensing, investigation, research, and education.

The majority of the Wadsworth Center's MCHSBG activities are based in the **Division of Genetic Disorders**, **Laboratory of Newborn Screening** and **Genetic Services**. Wadsworth performs specialized diagnostic and reference laboratory services; manages comprehensive statewide newborn metabolic screening programs; conducts a quality assurance program in cytogenetics, oncofetal antigens and DNA genetic testing; and undertakes research in genetics. This laboratory also administers a registry of infants identified by newborn metabolic screening and tracks their referral to treatment centers. They provide oversight and fiscal administration for genetic screening and counseling and have supported the Federally-designated Region II genetic network, GENES. Wadsworth Laboratories works closely with Division of Family Health to ensure those testing positive to genetic tests are linked to CSHCN Specialty Centers.

Regional Offices are a cornerstone of our assessment, monitoring and technical assistance capacity. Out-stationed in the regions are approximately 278 public health staff, including **Regional Public Health Program Nurses, Public Health Nutritionists, Epidemiologists, Public Health Representatives**, **Sanitarians** and **support staff,** that are in contact with MCHSBG-funded and other MCH-related programs on a daily basis. Through a strong regional

presence, the Department is able to quickly recognize emerging local trends, effectively mobilize resources, coordinate and link program efforts, and provide a stable, long-term relationship with contractors and other key players in maternal and child health.

Figure 28.
Core Public Health Services Delivered By MCH Agencies In New York State



a. State Capacity to Provide Direct Health Services

Please see previous explanations of the Family Planning, Rape Crisis Program, the Migrant Health Program, School-based Health Centers, American Indian Health Program, and the Dental Preventive Health Programs under ***Overall Capacity***.

Health Workforce: According to HRSA State Health Workforce Profiles for New York, released in December 2000, New York had a total of 48,113 active patient care physicians in 1998. At 265 physicians per 100,000 populations, New York is well above the national average of 198 per 100,000. New York ranked second among the 50 states for physicians per capita. New York had 73 active primary care physicians per 100,000 populations in 1998, compared to 59 per 100,000 in the US. Minorities are under-represented. Only five percent of active physicians in New York are African American and four percent are Hispanic/Latino, compared to a general population of about 15% of each.

New York is also fourth in the country for the number of dentists in the state, and fourth in the US for number of psychologists. New York ranks 15 out of 50 for number of registered professional nurses, tenth for number of nurse practitioners, and first for number of home health aides. New York ranks 48 out of 50 states for number of emergency medical technicians.

These rates do not tell the full story, however. While New York has plenty of personnel in terms of numbers, the distribution of health professions is uneven. The Federal government has helped support workforce development and to ease maldistribution through several Health Resources and Services Administration (HRSA) programs. According to HRSA's State Profile for New York, in addition to the Block Grant and Ryan White Act funds, HRSA helps fund:

- 36 Community/Migrant Health Centers;
- 14 Health Care for the Homeless grantees;
- one Health Services in Public Housing grantee;
- 93 State loan re-payers;
- 30 National Health Service Corps (NHSC) scholars;
- 117 participants in the NHSC Loan Repayment Program;
- 240 NHSC providers, including 133 primary care physicians, 8 non-primary care physicians, 32 physician assistants, 27 nurse practitioners, 27 dentists, and 13 certified nurse midwives;
- the State Office of Rural Health, two rural health outreach grants, one state rural hospital flexibility grant and three rural health network development grants;
- nine training grants to improve workforce diversity;
- 56 scholarship and loan programs for disadvantaged and/or financially needy students in health professions;
- 101 training grants to improve access to health care for the underserved;
- 12 training grants to improve public health;
- five projects training maternal and child health professionals;
- a Workforce Information and Analysis State Center for Excellence;
- two emergency medical services for children grants;
- five Healthy Start communities;
- three Emergency Relief Assistance (Title 1) programs in the City of New York, Dutchess and Nassau Counties;
- a grant for HIV/AIDS care, including the AIDS Drug Assistance Program;
- nine HIV/AIDS programs for children, youth and families;
- one AIDS Educational Training Center
- seven new models of AIDS care;
- 31 organizations providing oral health services to people living with HIV/AIDS; and

- one traumatic brain injury grant.

All of these programs share these common goals: to increase access to comprehensive, high-quality, primary and preventive care, to improve access for vulnerable and underserved populations, and to strengthen the safety net within communities to address the needs of the vulnerable populations at risk for poor health outcomes. This assistance is helping New York and HRSA to meet mutual goals for "100% access, zero disparities."

This year, the Governor's budget set aside $58.4 M for health workforce recruitment and retention to help facilities continue delivering high quality health care to community residents during one of these challenging times for recruitment in health care.

Public Insurance/Public Goods: In the summer of 1996, the **New York State Health Care Reform Act (HCRA)** was adopted, fundamentally changing our State's reimbursement system and providing new and innovative ways to pay for "public goods." Under HCRA, beginning in January 1997, hospitals began to negotiate their own rates of reimbursement with all payers except Medicaid fee-for-service, no-fault automobile insurance, workers' compensation, and Medicare. Graduate medical education reform, charity care, rural health, primary care development, and insurance initiatives were all addressed by "HCRA '96." At the same time, Governor Pataki signed a Medicaid managed care bill making available to consumers more detailed information concerning health coverage options; establishing grievance procedures, due process protections, and standards for utilization review; and establishing requirements for adequate provider capacity and access to specialty care. Integrated health networks began replacing more traditional delivery structures, producing a variety of new partnerships and enterprises. More and more New Yorkers began receiving their health care from managed care organizations.

There were multiple hospital mergers and acquisitions between 1997 and 2000: 20 in 1998, 9 in 1999 and 8 in 2000. Only two hospitals closed between 1997 and 1999. According to the Urban Institute, this number can be compared to 22 hospitals in California that closed in the same period, and 15 in Texas. Mergers and acquisitions may have made the hospital market more efficient, which will lower costs in the long run. Closures are monitored carefully, with the concern being loss of access, especially for low-income individuals. This year, a Commission on Health Care Facilities in the 21st Century has been appointed to re-evaluate the level of need for acute care facilities in the state.

In December 1999, the Health Care Reform Act was renewed. **"HCRA 2000"**, as it is called, continued the State's ability to provide for the public good and significantly expanded care for the uninsured and underinsured. It enabled Family Health Plus, modeled on New York's successful Child Health Plus Program, to make comprehensive health insurance available at no cost to lower-income, uninsured adults, ages 19 through 64, who do not have employer-sponsored coverage and who are not eligible for Medicaid or Medicare. Like the arrangement for Child Health Plus, Family Health Plus enrollees can access services through participating managed care plans, and parents may join the same plans as their Child Health Plus- or Medicaid-enrolled children. Income eligibility varies depending on the applicant's family size and whether or not he/she lives with a child. New York's waiver to implement Family Health Plus was approved by the Center for Medicare and Medicaid Services (CMS) and is now implemented.

Health Insurance Initiatives: Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual

delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

New York is committed to removing the most significant barrier to health care: lack of health insurance. In 1995, 16% of New Yorkers were uninsured, including 21% in urban areas. Approximately 2.9 million New Yorkers had no health insurance coverage in 1995. The young have been disproportionately affected, with more than 25% of young adults and 14% of children under age 18 lacking coverage. By 1997, it was estimated that between 400,000 and 680,000 children under the age of 18 were uninsured. The U.S. Census Bureau reported that the three-year average percentage of uninsured for children with family incomes at or below 200% of poverty for 1997, 1998 and 1999 was 9.0%.

These data have now turned around. The uninsured rate for children initially rose in the mid-90s despite the availability of Child Health Plus (New York's low cost health insurance program for the uninsured and underinsured) and an expansion of Medicaid. Then, in 1998, for the first time in four years, the proportion of uninsured children between the ages birth and 17 declined to 13.8% and further declined to 11.5% in 1999 and 10.5% in 2000. Helping families enroll in Medicaid and Child Health Plus through community-based facilitated enrollment programs and heavy advertising on billboards and primetime television seem to be having an impact.

The reasons for being uninsured or underinsured were many. Urban Institute data show that a smaller percentage of New York's employers offer health insurance than in the US as a whole (64.0% in 1999 compared to 66.7% for the US). Many employers offer insurance for the employee only, and offer family coverage only at unaffordable high rates. Families have testified that the rates offered are too high for the families to "buy in" to family coverage. As a result, they told us, fathers are covered by their employers, young children were covered by Child Health Plus, but many mothers and older children were not covered at all. New York's insurance programs for the uninsured and underinsured are helping. In addition to offering these families Child Health Plus, families like these were targeted for Family Health Plus, a State insurance program. The Healthy New York Insurance Program is also helping.

Another very significant reason for the high rate of un-insurance was thought to be that the public did not always understand the difference between cash assistance and Medicaid. Fewer people were applying for cash assistance and are waiting until they had an acute medical need before applying for Medicaid-only benefits. The Office of Medicaid Management then worked with Local Departments of Social Services to help remedy this situation.

The high number of immigrants in New York State must certainly be another factor in the number of remaining uninsured. There has been misunderstanding among the documented immigrant communities regarding use of Medicaid and Child Health Plus being used to "count against" immigrants as having used public services (a "public charge"). The Immigration and Naturalization Service (INS) has issued statements to try to correct this misinformation about public charge, and Office of Medicaid Management has also provided guidance to local districts on this ruling.

There have been three situations in which undocumented immigrants in New York have been entitled to government coverage: 1.) uninsured children are eligible for Child Health Plus under the state-financed portion of the program; 2.) anyone accessing care at an emergency room has been eligible for emergency Medicaid; and 3.)poor, undocumented immigrant women were eligible for prenatal care.

In May 2000, the United States Court of Appeals for the Second Circuit, in Manhattan, ruled that undocumented immigrant women are not entitled to federally financed prenatal care. This ruling overturned a 1991 Federal District Court Lewis v. Grinker ruling that ordered the federal government to provide prenatal care (care of the unborn) for undocumented immigrants. The children born of those pregnancies, who are US citizens, are still automatically eligible for one full year of Medicaid benefits after their birth. The Court of Appeals sent the ruling back to a lower court for a decision as to how to carry out this ruling, which would affect approximately 13,000 women. It was decided that undocumented immigrant women would continue to receive prenatal care until the lower court provided guidelines.

Then, Governor Pataki signed Chapter 16 of the Laws of 2002, which amends the Social Services Law to continue to provide Prenatal Care Assistance Program (PCAP) coverage to undocumented aliens as a State-only funded program. This became effective February 1, 2002. Now, no matter what the court ruling on Lewis v. Grinker, undocumented women in our State will be able to receive comprehensive services under PCAP.

Ensuring access to health care coverage for the uninsured and underinsured remains a very high priority in New York State. New York State's Title V Program will continue to work with **Medicaid, Medicaid Managed Care, Child Health Plus** and **Family Health Plus** to address access to care through these major public insurance programs.

Medicaid and Child Health Plus A (Children's Medicaid): There have been major expansions in New York's Medicaid Program over the last few years relative to the maternal and child health population. Medicaid also administers or provides access to several special programs and federal waivers designed to improve the health of Medicaid-eligible women and children. County governments play a major role in administration of Medicaid and TANF in New York; counties contribute 25% of the costs for these programs.

Most children under age 19 who have been determined eligible for Medicaid now receive **12 months of continuous coverage**, even if their family's income exceeds eligibility levels during that year. Infants up to one year of age through five may be eligible with incomes up to 200% FPL. Children ages one through five may be eligible with incomes up to 133% of the Federal Poverty Level, and children from age 6 through 18 years of age may be eligible with incomes up to 100% of the Federal Poverty Level. There is no resource test for Medicaid eligibility for children under age 19.

Pregnant women may be eligible with incomes up to 200% of the FPL and have no resource test. Coverage continues through 60 days postpartum. An infant born to a woman eligible for and receiving Medicaid is eligible for Child Health Plus A until the end of the month in which the child turns age 1.

The **Family Planning Extension Program:** Women and adolescents residing in New York State and insured by Medicaid during their pregnancy who lose Medicaid eligibility for any reason are eligible for up to 26 months of family planning benefits immediately following their pregnancy. These women are eligible whether their pregnancy ended in miscarriage, live birth, stillbirth or induced termination. At present the program is only available from our contracted Family Planning Providers. Undocumented women are eligible for this program. The federal Medicaid Program supports 90% of the cost of family planning services for eligible women. The benefit package includes all services normally provided by family planning programs for their patients.

There is also a **Family Planning Benefit Program,** the waiver for which was approved by the Centers for Medicare and Medicaid Services (CMS). One of the major limitations of the Family

Planning Extension Program is that a woman needs to first become pregnant to be eligible for its services. Governor Pataki and the Legislature addressed this issue by expanding family planning eligibility based solely on the countable income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. Both men and women are eligible. New York is one of a limited number of states that have pursued this approach. Under the waiver, Federal Medicaid will support 90% of the cost of contraceptive services for eligible women and men and the State pays the other 10%. No local share is required of the counties.

Pregnant women and infants under age one who have countable income at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. With this Medicaid expansion, more pregnant women can now choose to enroll in the clinic-based **Prenatal Care Assistance Program (PCAP),** or **MOMS**, the private physician model, for a special package of prenatal care services: nutrition screening and referral, psychosocial screening and referral for needed services, health education on a wide variety of topics, laboratory services, prescriptions, inpatient care, antepartum and postpartum services, and related services such as dental services and home visiting, as needed. PCAP and MOMS also offer presumptive Medicaid eligibility for women seeking coverage, a streamlined way to obtain care immediately where eligibility is verified after the fact. As previously stated, PCAP will continue to be available to low-income undocumented pregnant women as a State-only funded initiative.

Timely, risk-appropriate, coordinated, comprehensive prenatal care is provided to all **Prenatal Care Assistance Program (PCAP)** and **MOMS Program** enrollees. PCAP and MOMS require adherence to Part 85.40 standards of prenatal care, and all managed care plans serving Medicaid women are required to adhere to these comprehensive standards, as well. The provision of high quality prenatal care and appropriate level of care mandated by the standards was shown to reduce low birth weight rates among Medicaid women, particularly minority women, when compared to non-participants. In studies comparing Medicaid women receiving care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS clients had consistently better birth outcomes, and these outcomes were better even at the lower birth weights. Presumptive eligibility helps ensure timely entry into care.

The **Newborn Project** has taken steps to enroll all newborn children born of women on Medicaid within fifteen business days of birth. In this way, Medicaid coverage is assured for babies during the first year of life, a critical time for many babies born to low-income families. Enrollment is now facilitated via the Statewide Perinatal Data System (SPDS), or, in New York City, the electronic birth certificate.

Medicaid provides comprehensive health care to both medically needy and categorically eligible children in the State under the aegis of **EPSDT**, known in New York as the **Child/Teen Health Program (C/THP)**. Using a broad definition of medical necessity, Medicaid covers medical, mental health and substance abuse in a rich service package. New York is currently reviewing their EPSDT standards, and recently developed a new provider manual describing the EPSDT benefit, and adopting the American Academy of Pediatrics Guidelines as their standard of care, except in cases where State law contravenes. Title V staff was involved in the process.

Medicaid has also undertaken many **special initiatives** to promote access to quality care for children:

- **Teenage Services Act (TASA) Case Management:** More than half of our county departments of social services choose to meet their state obligation to provide TASA case management to pregnant, parenting and at-risk teenagers through Medicaid targeted case management.

- **Early Intervention (EI):** Medicaid provides targeted case management and the full complement of EI services to developmentally delayed, Medicaid-eligible children ages birth to three participating in New York's Early Intervention Program.

- **Preschool and School Supportive Health Program:** For Medicaid-eligible children ages three through twenty, Medicaid also reimburses counties and school districts for the provision of a wide array of medically-related services in the students' individualized educational programs.

- Medicaid reimburses **school-based health centers** located in designated high-need areas of the State that meet children's health, mental health and dental needs in the school setting.

- Several federal **Home- and Community-Based Services Medicaid Waivers** allow the State to provide non-traditional services in the community to populations of special needs children who qualify for institutional placement. There are waivers specifically for physically disabled children and for developmentally disabled children who would not otherwise qualify for Medicaid coverage. Developmentally disabled children may participate in a waiver program that includes the family home, as well as small-scale residential alternatives to Intermediate Care Facilities and a wide array of habilitative services to developmentally disabled adults and children. There is also a waiver operating in many counties in the State to cover children who have serious emotional disturbances. This waiver provides innovative treatment to children who would ordinarily be in in-patient psychiatric settings. Recently the age of eligibility for the Traumatic Brain Injury Waiver was lowered from age 22 to age 18 and the requirement that the age at which the injury occurred be after the individual turned 18 has been removed.

- Medicaid has also utilized fee enhancement as an approach to promoting access to quality care. The **Preferred Physicians and Children's Program (PPAC)** has been in operation for over ten years and has brought and retained thousands of highly qualified pediatricians, family practitioners and nurse practitioners into Medicaid.

- In marketing the Medicaid program for children statewide, the State has adopted the name **Child Health Plus A** for children's Medicaid. It was hoped that this might remove any perception parents might have of a stigma attached to Medicaid. The name change also underscores efforts to make the two programs as seamless as possible.

- Medicaid has collaborated extensively for several years with the State Office of Children and Family Services to improve access to health care services for children in Foster Care by upgrading the eligibility process, revamping policies and procedures, sharing Foster Care Medicaid data with counties, and troubleshooting the child care agency rate-setting process. Title V staff have been involved, as well. Many major improvements to care have resulted for this special needs population.

Medicaid Managed Care: More New Yorkers than ever before are receiving care through managed care providers. According to the Medicaid Managed Care Monthly Enrollment Report, enrollment as of May 2003 and April 2004, is as reflected in the chart below.

Medicaid Managed Care Enrollment by Location *Source:* NYSDOH Office of Managed Care				
Enrollment As of May 2003				
	Total # Eligibles	Total # Enrollees	% Eligibles Enrolled	% Of Target Enrolled
New York City	1,653,412	1,116,564	68%	
Rest of State	799,031	452,130	57%	
Total NYS	2,452,443	1,568,694	64%	
Enrollment as of April 2004				
	Total # Eligibles	Total # Enrollees	% Eligibles Enrolled	% Of Target Enrolled
New York City	1,868,310	1,341,965	71%	89%
Rest of State	898,740	515,087	56%	70%
Total NYS	2,766,870	1,857,870	67%	83%

Eventually, about 2.4 million New Yorkers will be covered under the Partnership Plan. Mandatory Medicaid managed care represents the single greatest effort the State has made to ensure that every New Yorker with Medicaid has access to high-quality primary care in a "medical home" model. This ensures that more care takes place within the context of the primary and preventive care setting, with less reliance on more expensive and less continuous forms of care, including the emergency rooms.

Health Plans participating in Child Health Plus A (Medicaid) and B are required to submit New York's **Quality Assurance Reporting Requirements (QARR)** reports annually. Among other measures, the QARR contains measures of preventive care and health outcomes related to maternal, infant, child and adolescent health.

According to the Quality Assurance Reporting Requirements (QARR) Report, there have been significant advances in the quality of care for individuals in Medicaid managed care. With eight years of QARR data, we have seen a trend in which the difference between the historically under-served Medicaid population and those individuals with private insurance has narrowed or disappeared with respect to primary care access and receipt of preventive services. There has been continuous improvement in usage of screening mammograms, cervical cancer testing, and immunizations. In addition, with respect to care of people with chronic diseases like asthma, heart disease and diabetes, there has been an improvement in the delivery of recommended interventions that will positively impact health outcomes. The Department, providers and plans are engaged in prioritizing areas for further quality improvement, which is further advancing the health status of New Yorkers.

The Child Health Plus B Program: Child Health Plus B provides free or low-cost private health insurance to children from age one month to age 19 in low-income working families who are not eligible for Medicaid. The program is paid for through a combination of state funding and federal funding under Title XXI, the State Child Health Insurance Program (SCHIP). The program encourages parents to seek routine primary and preventative care, resulting in healthier children.

The Child Health Plus B Program holds the potential for near universal coverage of New York's children. Currently, families with incomes at or below 250% of the FPL, or $47,125 for a family of 4, are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus B is available at full premium. There are no co-payments for services. *Table 13* below indicates current eligibility levels.

Table 13. 2005 Income Eligibility Levels for Child Health Plus A and B (Based on Initial 2005 Federal Poverty Levels)						
Child Health Plus A – Children's Medicaid						
Age Categories for Children	**Monthly Income for Family Size****					**Each Additional Person, Add**
	1	**2**	**3**	**4**	**5**	
Children under 1 year; Pregnant women**	$1587	$2130	$2674	$3217	$3760	$544
Children 1 – 18 years	$1056	$1417	$1778	$2140	$2501	$362
*****Pregnant women count as two when determining family size.***						
Child Health Plus B						
Premium Category	**Monthly Income for Family Size****					**Each Additional Person, Add**
	1	**2**	**3**	**4**	**5**	
Free Insurance	$1269	$1703	$2138	$2573	$3007	$435
$9 per Child per Month ($27/family maximum)	$1762	$2365	$2968	$3571	$4174	$604
$15 per Child per Month ($45/family maximum)	$1984	$2663	$3342	$4021	$4700	$680
Full Premium per Child per Month	Over $1984	Over $2663	Over $3342	Over $4021	Over $4700	xxxxxxx
*****Pregnant women count as two when determining family size.***						

As of April 2005, a total of 321,569 children were enrolled in Child Health Plus B and an additional 75,000 were enrolled in Child Health Plus A. See *Table 14* for the number of children enrolled in each age group. Approximately 14.9% of the children ever enrolled in the national child health insurance program are New York State-enrolled Child Health Plus children in 2004.

According to a recent report by the Urban Institute, the extent to which Medicaid and Child Health Plus reach uninsured children varies with the characteristics of the child. Younger children participate at higher rates than older children. Also, children with health issues were more likely to participate than other children. This is not surprising, given that younger, sicker children tend to have more contact with the health care system.

Table 14. **Number of Child Health Plus Enrollees by Age, by Point in Time December 1997, May 1998 and 1999, March 2000, April 2001, 2002, 2003, 2004**																
Ages	**May '98**		**May '99**		**March '00**		**April '01**		**April '02**		**April '03**		**April '04**		**April '05**	
	#	**%**	**#**	**%**	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Birth-1 Yr.	5,013	3	9,086	3	13,122	2.7	10,339	2	10,471	2	7,916	2	6,073	1.7	3,846	1.2
1 – 9	110,845	57	180,528	55	260,018	53.5	254,419	51	250,880	47	192,648	46	167,441	46	142,532	44.3
10 – 14	52,019	27	87,851	27	133,168	27.4	146,073	29	164,223	31	126,325	30	109,444	30.1	98,394	30.6
15-19.1	24,354	13	49,716	15	79,707	16.4	90,107	18	111,588	21	89,059	21	81,020	22.3	76,797	23.9
Total	**191,385**		**327,181**		**486,015**		**500,993**		**537,162**		**486,015**		**359,910**		**321,569**	

The Family Health Plus Program: With the enactment of the Health Care Reform Act of 2000, the Governor and the Legislature authorized the Department of Health to apply to CMS for an amendment to the Partnership 1115 Waiver, which when approved, enabled New York to establish the **Family Health Plus Program.** Like the **Child Health Plus B Program**, this program offers comprehensive health insurance at no cost to low-income, uninsured individuals who are not income-eligible for Medicaid due to income or resources. However, unlike the Child Health Plus B Program, Family Health Plus is a Medicaid funded program and it is for adults only. As of April 2004, enrollment in Family Health Plus exceeded 390,000. To qualify, the individuals must be between the ages of 19 and 65 and not meet the criteria for Medicaid but meet the following income criteria:

- In the case of an adult with children under the age of 21, gross family annual income is up to 150% of the Federal Poverty Level or $29,025 for a family of four.
- In the case of a single adult, gross family income is up to 100% of the Federal Poverty Level or $9,570 per individual.

Current eligibility is as follows in *Table 15.*

Table 15. **Maximum Gross Annual Income for Family Health Plus**
Effective January 1, 2005

Maximum Income	Family Size								Each Add'l Person, Add:
	Single Adult	Couple, No children	2	3	4	5	6	7	
Yearly Income	$9,570	$12,830	$19,245	$24,135	$29,025	$33,915	$38,805	$43,695	$4,890
Monthly Income	$798	1,070	1,604	2,012	2,419	2,827	3,234	3,642	$408
Weekly Income	$184	247	370	464	558	652	746	840	$94

Family Health Plus does not consider assets and other resources in determining eligibility. The Family Health Plus managed care benefit package is similar to that of Child Health Plus, covering:

- physician services;
- inpatient and outpatient health care;
- prescription drugs and smoking cessation products;
- laboratory tests and x-rays;
- vision, speech and hearing services;
- rehabilitative services (some limits may apply);
- durable medical equipment;
- radiation, chemotherapy, and hemodialysis;
- emergency room visits and emergency ambulance services;
- behavioral health and chemical dependence treatment services (some limits may apply);
- hospice services;
- diabetic supplies and equipment; and
- dental services (if offered by the plan).

A toll-free help-line is currently available at 1-877-934-7587 or 1-877-9FHPLUS.

Coordination: Under these initiatives and expansions, the Department is striving to make the transitions between these systems seamless to the consumer in every way possible. Facilitated enrollers provide outreach and application assistance to Medicaid, Child Health Plus and Family Health Plus programs and a joint Medicaid-Child Health Plus-Family Health Plus-WIC application has been implemented. To facilitate children's retention of their primary care provider, most Child Health Plus providers are also Medicaid managed care providers. Many of the Family Health Plus

providers participate in Medicaid managed care, as well. Quality is also being monitored in a coordinated fashion, with plans participating in New York's public insurance program required to submit reports annually.

The Title V programs continue to have a role in outreach, enrollment, standards development, quality assurance and evaluation.

Dental Rehabilitative Services: Dental rehabilitative services are available both under the Medicaid Program and the Physically Handicapped Children's Program. Screening clinics are provided in Article 28 facilities in New York City and Nassau and Suffolk Counties. The Department is piloting a new process for the Dental Rehabilitation Program in Upstate counties that bypasses screening clinics and allows initial evaluations to be done by the child's orthodontist. In all Upstate counties, children who are financially eligible for services have direct access to orthodontists who perform screening exams and request authorization for the services through NYSDOH. Additional Diagnostic and Evaluation funds are used for non-Medicaid recipients who sought services under the Physically Handicapped Children's Program.

School-Based Health Centers: School-based health centers were established in New York under Chapter 198 of the Laws of 1978. Under this statute, school-based health centers are jointly established by the Commissioner of Education and the Health Commissioner. New York establishes these centers only in areas of high need for services and under the auspices of an Article 28 facility (hospital or diagnostic and treatment center). New York currently has over 180 of these centers, serving approximately 120,000 children. This year, the Department began authrorizing freestanding school-based dental services under this same provision of law.

Federally Qualified Health Centers/Community Health Centers: As the state primary care agency, the Department of Health is a partner to a three-way **Cooperative Agreement** with the US Public Health Service and the Community Health Care Association of New York State (CHCANYS), the organization representing the bulk of the Federal 330 contractors in New York. This cooperative agreement provides the basis for mutual support of primary care development. Community Health Centers are often contractors for DOH initiatives under MCH, Family Planning, School-based Health Center and the Primary Care Initiatives. CHCANYS and Department staff will assist localities with obtaining designation as a medically underserved are or a health professional shortage designation.

Other Primary Care and Insurance Initiatives: Under the Health Care Reform Act (HCRA), funding is designated to **encourage education of minorities in health professions**, and monies are available for **loan repayment**.

The **Healthy New York Insurance Program** is available to pay health insurance premiums for employers with 50 or fewer employees who have not offered health insurance to their employees for at least one year. In addition, individuals whose employers do not offer health insurance coverage or who lost their coverage may purchase comprehensive health insurance directly through the Healthy New York Program. All of the State's Health Maintenance Organizations (HMOs) are required to offer the Healthy New York standardized, steam-lined, low-cost managed care benefits package. The cost of the coverage is split between the employer and the employee. There is a mandated 90% reimbursement rate for claims between $30,000 and $100,000 per member per year. Governor Pataki recently announced that premiums under the Healthy New York Program were cut by an average of 17%, making the program even more affordable.

Eligibility requirements for working, uninsured individuals are as follows:
- The individual's employer does not provide health insurance;
- The individual's gross family income meets the guidelines in the chart below;

- The individual did not have health insurance in effect for the 123-month period preceding application or lost insurance due to a qualifying event (loss of employment, death of a family member, change to a new employer, change in residence, discontinuation of a group health plan, termination or cancellation of COBRA coverage, legal separation or divorce, annulment, loss of eligibility for group insurance coverage, reaching the maximum age for dependent coverage);
- The individual is ineligible for Medicare;
- The individual resides in New York; and
- The individual or the individual's spouse is currently employed or has worked some time in the past year.

Healthy New York Income Guidelines* 2005 *Family size is not related to whether you are purchasing individual, spousal or family coverage. Pregnant women count as two people for the purpose of calculating family size.		
Family Size	**Annual Household Income**	**Monthly Household Income**
1	Up to $23,800	Up to $1,984
2	Up to $31,950	Up to $2,663
3	Up to $40,100	Up to $3,342
4	Up to $48,250	Up to $4,021
5	Up to $56,400	Up to $4,700
Each extra person	Add $8,150	Add $680

New York in 1992 passed a landmark **community ratings** law that established subsidies for insurance companies serving the individual and small groups market. This law allows insurers that serve these markets to draw down donations to a pool to cover costs of serving a disproportionate number of sick enrollees due to adverse selection.

The **Catastrophic Insurance Program** assists low-income, uninsured New Yorkers facing devastating medical bills. HCRA also created a new **Individual Health Insurance Program** to defray the cost of premiums for people with incomes below 200% FPL, and a **Cancer and Children Initiative** provided grant funds to health care providers to expand access and quality of cancer services and for specialty cancer and children's hospitals. The **AIDS Drug Assistance Program** helps employed persons with HIV or AIDS purchase expensive medications that they need to control their illness.

The **Community Health Care Conversion Demonstration Project (DHCCDP)** is a federally funded initiative targeted to those hospitals that historically have served a substantial number of Medicaid recipients and the uninsured. The project's aim is to assist hospitals in transitioning to a Medicaid managed care environment and to continue to meet the health care needs of low income New Yorkers. During the five years of this program, $1.25 billion was be awarded to hospitals on a non-competitive formula basis. Funded hospitals were asked to focus their activities within three broad areas: worker retraining; primary care expansion and managed care readiness.

In 2000, New York State ranked third nationally for number of physicians per 100,000 civilian population, and third in per capita health care expenditures. However, New York has 102 **federally-designated primary care shortage areas and facilities** with more than 3.8 million people residing in them, mostly rural and inner-city areas. Access to care in rural areas is especially variable. Providers are usually clustered in small cities and towns, but are caring for residents whose homes are scattered over larger geographic areas. Access problems can be exacerbated by a shortage of health personnel and by fiscal constraints of rural health care facilities. HCRA 2000 continued numerous provisions designed to assist rural areas and rural

hospitals. Local communities are assisted in completing their applications for shortage designation by staff from the Department of Health.

The **New York State Council on Graduate Medical Education** has been involved in developing policies that support the education of primary care physicians, expanding opportunities for training of physicians who are under-represented minorities, and expanding use of community-based ambulatory care sites as training sites for physicians. In addition, New York's **Area Health Education Centers** are expanding opportunities for training students in primary care and for engaging students in health careers.

As the designated **Primary Care Organization**, the State Health Department sponsors or collaborates with several programs designed to increase the health workforce in underserved areas of New York State. These include the federally-funded **National Health Service Corps** loan repayment and scholarship programs and the a state-funded scholarship program, the **New York State Regents Scholarship Program in Medicine and Dentistry.**

The **National Health Service Corps,** with two program components, is highly competitive. The **National Health Services Corps Loan Repayment Program** pays up to $25,000 annually for two years and $35,000 annually for two renewal years. There is one year of obligated service for each year of assistance. The **National Health Services Corps Scholarship Program** pays tuition, fees, books, supplies, equipment and a monthly stipend. The program will pay for up to four years of assistance, with one year of obligated service for every year of assistance. The **Regents Scholarships in Medicine and Dentistry Program** gives disadvantaged minority candidates priority in accessing up to $5,000 annually in tuition, fees, books, supplies and equipment for up to four years, with one year of obligated service for each year of assistance.

Private Sector Resources: New York remains a world center for commerce, learning, finance and the arts. In a time of increasing government fiscal restraint and increasingly complex social and health issues, private sector resources are increasingly called upon to help improve the health of communities. Businesses hold great purchasing power as suppliers of employee benefits and purchasers of health insurance coverage. Business and unions have helped to set the health care agenda and to assist New York in meeting goals for health insurance enrollment, as well. To enhance its competitiveness in national and international markets, and to retain its international stature in business, education, the arts, research and development, continued collaboration from all sectors, including business and private concerns, is expected, enlisted and enjoyed. The New York State Department of Health regularly partner with the private sector to address issues related to health, education and public health and safety. Business is a major force in ensuring access to health care and insurance coverage for all New Yorkers.

According to the National Survey of America's Families (NSAF), private employer-sponsored health insurance in 1999 covered about 70.8% overall of adult New Yorkers ages 19 to 64 and about 64% of those under age 19. Not surprisingly, the percentages are higher in those with incomes over 200% of the Federal Poverty Level, where employer-sponsored insurance covers 84.6% of adult New Yorkers ages 19 to 64, and 86.5% of those under age 19. (US averages are 83.7% and 85.3%, respectively.)

Overall, New York is also doing better than the US average for insuring the poor uninsured. NSAF data shows 16.1% of New Yorkers under age 19 and under 200% of the Federal Poverty Level to have been uninsured in 1999, compared to 22.4% as the US average. For adults ages 19-64 under 200% of poverty, 32.1% of New Yorkers are uninsured, compared to 34.9% as the US average.

b. Capacity to Deliver Enabling Services

Please see descriptions of Community Health Worker Program, Care Coordination Waivers, Health Education, Transportation, Translation, Outreach, Family Specialist, Sudden Infant Death Follow-up Services, the Dental Rehabilitation Program, Children with Special Health Care Needs, Physically Handicapped Children's Program.

Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department of Health under the **Comprehensive Prenatal/Perinatal Services Network** initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize our mutual effectiveness. During the past year, Healthy Start grantees met with the Department on a number of occasions to explore opportunities for collaboration. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in order to foster better communication, explore areas for potential collaboration and share late-breaking developments. Regional staff meet with the Networks on a routine basis.

Family Support New York: The goal of this collaborative is to advance an agenda that transforms public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

Adolescent Pregnancy Prevention and Services (APPS) Program: The **Office of Children and Family Services** also administers the **Adolescent Pregnancy Prevention and Services (APPS) Program**, providing prenatal support and parenting education to high-risk teens in high need communities.

Family Planning/TANF Outreach: In 2005, the State Legislature allocated $2.1 M in funding from the federal **Temporary Assistance to Needy Families (TANF) Block Grant** to the Department of Health for outreach and education activities to prevent unintended pregnancies. Family Planning Program providers provide outreach and education activities in community settings, including schools, to educate children and adults regarding reproductive health and to provide programs to prevent adolescent pregnancy. TANF funding expanded the program consistent with state and federal priorities, including:

- increased community education, public information and counseling to prevent adolescent pregnancy and increase access to clinic service for sexually active teens;
- increased outreach to women not likely to seek services, especially underserved minorities, homeless and substance-abusing women;
- improved access in underserved areas to women and adolescents at risk for unintended pregnancy.

This year, $10 M in HCRA funds were added to provide expanded outreach to low-income adolescents and adults.

Coordinated Children's Services Initiative (CCSI): The goal of this collaborative is to improve local service coordination for children and adolescents with serious emotional disturbances and to reduce reliance on residential placements. The lead agencies are the State Education Department and the Office of Alcohol and Substance Abuse Services. Agency partners

include the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services.

c. Capacity to Deliver Population-Based Services

The Bureau of Women's Health supervises the operation of the toll-free **Growing Up Healthy Hotline (1-800-522-5006 and TTY 800-655-1789).** The hotline provides information to pregnant women, mothers, children and adolescents, and helps to ensure access to needed maternal and child health services. It operates 24 hours per day/seven days per week, with both English- and Spanish-speaking operators. Answering services are contracted to The Health Association of Rochester, a not-for-profit telecommunications group that specializes in community information and referral services. A requirement of the contract is that callers will be immediately connected to an information specialist, with no busy signal or answering tape, at least 94% of the time. The contractor actually achieves 98%, which is one of the best performances in the nation. In order to maximize its usefulness, the Growing Up Healthy Hotline provides services for the hearing-impaired and to people who are not English- or Spanish-speaking through the AT&T Language Line, extending the number of languages available to callers.

In 2004, the Growing Up Healthy Hotline provided information to 59,191 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. This total does not include 6,587 calls that were nuisance, hang-ups or otherwise erroneous. Under six percent (5.9%) of calls are handled in languages other than English. Of these calls, 3,131 or 5.7% of the total calls were from Spanish-speaking callers and 119 or 0.2% of the calls were in languages other than English or Spanish.

Last year, callers requested assistance in the following areas: adult insurance 0.1%, breast and cervical screening 0.1%, Child Health Plus 5.7%, child/adult care food program 0.4%, dental/orthodontia 0.5%, early intervention 2.1%, educational materials 1.1%, Family Health Plus 3.0%, family planning 3.0%, farmer's market 4.1%, food and nutrition programs 0.5%, health department programs 1.4%, immunizations 0.4%, Medicaid for adults 4.0%, Medicaid for children 1.1%, newborn screening 0.6%, pregnancy care 7.9%, social services 0.9%, summer food program 6.0%, WIC 53.7%, WIC complaints 1.3%, and other 2.1%.

When appropriate, callers are also given toll-free hotline numbers where they may have questions answered about AIDS, child abuse, domestic violence, substance abuse, and assistance for people with disabilities.

Title V staff periodically test the availability and accuracy of the hotline at various times, with positive results.

The declining percentage of calls about prenatal care has been a concern, even knowing that New York City Department of Health and Mental Hygiene operates a **toll-free hotline for the five boroughs of New York** that handles a substantial number of calls. New York State Department of Health implemented a statewide, multimedia prenatal care promotion campaign in 2005 using television, radio, and print media, including posters; bus sides, shelters and interiors; and subway interiors. The materials advertised the toll-free and TTY hotline numbers. The benefits of prenatal care and access to services under the Prenatal Care Assistance Program (PCAP) was broadly promoted and women were given the toll-free Growing Up Healthy hotline number to call for a link to local services. Our experience has been that the more media coverage there is, the greater the use of the hotline. As a result of the campaign, a 75%

increase in the number of calls (2,869 versus 1,638) requesting information on prenatal care was noted for the February to May 2005 compared to the same period in 2004.

New York also has a toll-free hotline for **Child Health Plus** calls, which is linked to take rollover calls from the National Governor's Association hotline. However, the volume of Child Health Plus-related calls remains very heavy on the Title V hotline. In 2003, the Growing Up Healthy Hotline received 11,267 calls for information about Child Health Plus. The Child Health Plus hotline offers certain advantages, in that they can provide the public with more in-depth information about eligibility for Medicaid and Child Health Plus. The number for the Child Health Plus hotline is 1-800-698-4KIDS or 1-800-698-4543.

The list below is a partial listing of statewide hotlines and info-lines serving mothers and children:

Toll-Free Hotlines Serving the Maternal and Child Health Population in New York State	
Title V Growing Up Healthy Hotline – covering: Immunization Child Health Plus Insurance Early Intervention Food and Nutrition, including WIC Infant Health Assessment Prenatal Care Sudden Infant Death Syndrome (SIDS) Teen Pregnancy Dental Health/Orthodontia	1-800-522-5006
Child Health Plus Hotline	1-800-698-4KIDS
Family Health Plus Hotline	1-877-9FH-PLUS
Child Abuse and Maltreatment Hotline	1-800-342-3720 (TDD 1-800-638-5163)
Domestic Violence Hotline	1-800-942-6906 (English) -6908 (Spanish) 1-800-621-HOPE (NYC English and Spanish)
Missing Children Hotline	1-800-FINDKID -- or – 1-800-346-3543
Child Care Complaint Hotline	1-800-732-5207
Child and Adult Care Food Program	1-800-942-3858
Disabilities Information Line	1-800-522-4369
HIV/AIDS Information Service	1-800-541-AIDS; Spanish: 1-800-233-7432
HIV/AIDS Drug Assistance Program	1-800-542-2437
HIV Counseling and Testing Hotline After hours Albany Area Buffalo Area Nassau County New Rochelle Rochester Area Syracuse Area Suffolk County	 1-800-872-2777 1-800-962-5065 1-800-962-5064 1-800-462-6785 1-800-828-0064 1-800-962-5063 1-800-562-9423 1-800-462-6786
Cancer Information Service	1-800-462-1884 or in Erie Co.: 716-845-3380
Cancer Maps	1-800-458-1158
Roswell Park Cancer Referral Services	1-800-767-9355
Ovarian Cancer Information	1-800-682-7426
Smokers Quit Line	1-866-697-8487
Medicaid Helpline	1-800-541-2831

Medicaid Managed Care	1-800-505-5678 – NYC only
Medicaid Billing Assistance for Instate Providers	1-800-522-5518 – Practitioner Assistance 1-800-522-1892 – Institutional Assistance 1-800-522-5535 – Professional Services
Medicaid Fraud Reporting Line	1-877-87FRAUD
Child Support Info Line	1-800-846-0773
New York State Parent Connection Hotline	1-800-345-5437
Environmental Health Info Line	1-800-458-1158
Drug Abuse Information Hotline	1-800-522-5353
Consumer Fraud Hotline	1-800-771-7755 (TTY 1-800-788-9898)
Crime Victims Board	1-800-247-8035
Mental Hygiene Complaint Line (MH facilities)	1-800-624-4143 (TTY 1-800-624-4143)
Mental Hygiene Customer Relations	1-800-597-8481 (TTY 1-800-597-9810)
Organ and Tissue Donation Hotline	1-877-752-3175
Managed Care Complaint Line	1-800-206-8125
Home Health Care	1-800-628-5972
Environmental Health	1-800-458-1158
Health Care Fraud Hotline	1-800-771-7755
Talking Book/Braille Library	1-800-342-3688
Office of Professional Discipline – for health care professions other than medicine	1-800-442-8106
Medical Conduct Complaint Line – physicians	1-800-663-6114

Local health departments and local departments of social services often get phone calls directly from the residents of their municipality. Local departments of health and social services are generally very active in providing information and referral services on a county level, as are the Comprehensive Prenatal/Perinatal Services Networks. Local agencies also have access to hotline numbers and directories in order to handle calls for residents outside of their districts.

Newborn Metabolic Screening: Under mandate of **New York State Public Health Law §2500(a)**, all newborns must be screened for the following disorders: phenylketonuria (PKU), congenital hypothyroidism, homozygous sickle cell disease, branched-chain ketonuria (Maple Syrup Urine Disease), galactosemia, homocystinuria, biotinidase deficiency and HIV. The **Newborn Screening Program** tests these samples, tracks findings, provides education and follows up on infants needing additional evaluation or treatment.

The purpose of testing newborns is to permit early detection and treatment of these conditions that, if untreated, lead to mental retardation or other disability. In 2004, 250,209 newborns were tested. (A complete listing of numbers served by newborn screening appears on Form 6 in Section 5.4.) The Newborn Screening Program consistently achieves 100% follow-up on confirmed cases. In 2001, three new tests were added: congenital adrenal hyperplasia, medium chain Acyl-Co-A dehydrogenase (MCAD), and cystic fibrosis. Local health units can and do use Article 6 State Aid reimbursement to pay for follow-up visits by public health nurses or bill insurance companies for these services. Children identified through the metabolic screening process are referred to Children with Special Health Care Needs Specialty Centers. NYSDOH is in the process of certifying/re-certifying various specialty centers.

Clinical genetics services, including follow-up genetics counseling for families of children with inborn metabolic errors are available through the **Genetics Program**. The Wadsworth Center for Laboratories and Research administers programs that cover services to over 24, 000 people annually.

Universal Newborn Hearing Screening: In 1999, the New York State Legislature passed and Governor Pataki signed a **bill requiring Universal Newborn Hearing Screening** in birthing hospitals in New York State. In 2000, the Department convened an Ad Hoc Work Group on Newborn Hearing Screening. This group advised the Department on the development of policies and procedures for newborn hearing screening, tracking, and follow-up as necessary to ensure successful expansion of the program to statewide. Final regulations were published for implementation in August 2001. New York has a four-year grant from the Health Resources and Services Administration to ensure that babies are appropriately screened, diagnosed and tracked for the timely receipt of needed services.

In the latter part of 2001, the program's focus shifted from development of regulations to provision of technical assistance and training to hospitals on the implementation of universal newborn hearing screening. In addition, public/parent education materials were developed and provided to facilities to coincide with the effective date of regulations. In 2001, the Department developed clinical practice guidelines and established quality assurance and review protocols with hospitals. State level review of protocols was initiated in 2001.

Health Information Materials: In 2004-2005, as in past years, the **Bureau of Community Relations, now renamed as the Bureau of Health Media and Marketing,** planned, developed, produced, distributed and/or evaluated MCHSBG-related materials and campaigns. The following is a partial listing of recent projects:

- Antibiotic Resistance (professional brochure, viral prescription order forms and prescription pads)
- As I Grow (new parent developmental guide and video)
- Asthma: Don't Let Asthma Knock the Wind Out of Your Child (statewide campaign, brochures in English, Spanish, French, Chinese, Russian and low-literacy versions; posters in English and Spanish; TV and radio spots; prescription form)
- Berenstain Bears Tobacco Use Prevention Initiative (booklets in English and Spanish for all second graders)
- Booster Seat Demonstration Project (activity book, jungle, CD-ROM, tambourine, sunglasses)
- Child and Adult Care Food Program (brochures and posters in English and Spanish)
- Dental Sealants Work Hard (stickers)
- Ear Infections in Children (brochure)
- Eat Well, Play Hard (nutrition and activity campaign for children)
- Fall Prevention for Children Birth to Three (brochure)
- Female Circumcision (brochure)
- Folic Acid Awareness Week (informational campaign)
- Having A Baby (booklet in English and Spanish)
- Maternity Information Law (brochure given to each mother upon registering for hospital maternity services)
- Molly and Michael Molar (about dental sealants)
- Newborn Hearing Screening Education (4 brochures and 7 posters in English, Spanish, Chinese, Creole, Russian, Urdu and Bengali)
- Parents Resource Directory for Families of Children with Special Health Care Needs (English, Spanish, French, Russian, Mandarin Chinese and Urdu)
- Pedestrian Safety (formative research/focus groups)
- Physician and Parent Guidelines for the Treatment of Otitis Media (brochure)
- Protect Your Baby from Smoke (brochure)
- Scooter Safety (brochure)
- Shaken Baby Syndrome (brochure, information kit, poster- see our website)
- Take Folic Acid Every Day (emery boards with countertop display holder)

- Welcome to Parenthood (packet given to every new mother after delivery, English and Spanish)
- WellNYS Weekend (health screening fact sheets)
- A Whale of a Smile (stickers)
- Your Guide to a Healthy Birth (booklet, English and Spanish)

The Bureau of Dental Health is currently working with the Bureau of Health Media and Marketing on revamping Oral Health information, based on a recent needs assessment.

Immunization Services: The **Immunization Program** provided vaccines through the **NYS Vaccines for Children Program**, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State funds were used to provide staffing in both central and regional offices. Both CDC and State dollars were used to purchase vaccines and support local immunization activities at county health departments. Laboratory reports of Hepatitis B surface antigen-positive mothers are follow-up to ensure that their infants received appropriate vaccinations and treatment.

Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not public clinics. Under the **Provider-Based Immunization Initiative**, county staff visit pediatricians and assess the medical records of their patients. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.

Childhood Lead Poisoning Prevention: The **Childhood Lead Poisoning Prevention Program** coordinates efforts to prevent, detect and treat childhood lead poisoning; educates the public and health professionals about prevention, early detection and appropriate medical management of childhood lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assistance in locating and eliminating sources of lead within the child's environment; provides lead-safe interim housing while lead hazards are being removed; and collects and analyzes statewide data on the extent and severity of childhood lead poisoning.

In New York, blood lead testing is done primarily by the child's medical provider. The Childhood Lead Poisoning Prevention Program has contracts with 58 local health departments to provide prevention programs and provide care coordination. Seven teaching hospitals serve as Regional Lead Resource Centers. Seven local health departments and community-based organizations provide interim lead-safe housing. Local health departments and State Health Department District Offices provide environmental assessments and assure lead hazards are corrected.

The Program has recently completed a comprehensive New York State Lead Elimination Plan in conjunction with the Center for Environmental Health.

Childhood Overweight Prevention: Eat Well, Play Hard was initiated in 1997 as a comprehensive response to the childhood overweight epidemic. The program's three-part strategy has been incorporated into all New York State Department of Health nutrition programs. To reduce the prevalence of overweight among New York State children, Eat Well, Play Hard promotes:

- Increasing developmentally-appropriate physical activity;
- Increasing the consumption of 1% or lower fat milk and low-fat dairy products; and
- Increasing the consumption of fruits and vegetables.

The Bureau of Child and Adolescent Health, in collaboration with New York State chapters of the American Academy of Pediatrics and the American Academy of Family Physicians will be distributing BMI growth charts and BMI wheels (to determine BMI) along with resource information on childhood obesity and interventions.

New interventions will focus on improving the health and fitness of young children and preventing the development of overweight among preschool children by targeting the environment where children spend an increasing amount of time: preschools, child care and Head Start centers. The Division of Chronic Disease Prevention and Adult Health will be testing community-wide interventions that will collaboratively develop food and physical activities guidelines and policies, increase physical activity, decrease television and video watching, and address behaviors that encourage overeating or discourage physical activity.

The Department of Health's **Maternal Mortality Program** was funded by the CDC via cooperative agreement with the **Association of Schools of Public Health**. A new collaboration on maternal mortality review has developed with the **American College of Obstetricians and Gynecologists** with funding from the New York State Health Commissioner's Priority Pool. The goal of this initiative is to institutionalize maternal mortality review as one of the responsibilities of the Regional Perinatal Centers. A protocol and data collection tool are complete and in use, and reviews of maternal deaths initiated.

Welcome to Parenthood, a packet given to the family of each newborn born in New York, contains information about normal growth and development, parenting, child safety, calming a crying baby, early intervention and childhood immunizations.

d. Capacity to Deliver Infrastructure-Building Services

The protection and promotion of the public's health is not possible without adequate public health infrastructure. Public health agencies must have the ability to perform adequate needs assessment, to appropriately evaluate public health issues and programs, to develop meaningful policies and standards, to engage their communities, to coordinate existing resources, to ensure quality, and to adequately train the public health workforce.

The Department is able to assess the adequacy of the infrastructure for maternal and child health services through:

- Establishing and maintaining regular multi-directional communication with local health departments, local contractors, our regional offices, other units within the State Health Department and other State and Federal agencies;

- Regularly and frequently monitoring the quality and the content of local health assessments, public health service plans and contractor workplans;

- Monitoring the ability of our programs, our contractors and county health departments to effectively achieve the desired results;

- Monitoring and auditing the use of available resources, including available technical assistance;

- Periodically reassessing our internal controls system for areas of vulnerability; and

- Performing special assessments relative to the ability of local agencies to perform essential public health services.

Health Insurance Infrastructure
New York has developed adequate infrastructure for health insurance (previously described under Overall Capacity and Capacity to Deliver Direct Medical Services), essential public health services, information, education and collaboration among agencies.

Health Services Infrastructure
Since most of the maternal and child health services delivered in this State are not delivered directly by the New York State Department of Health, not only is State infrastructure important, but the local infrastructure is also critical to the delivery of high-quality services. The Department employs various mechanisms to ensure that services are coordinated and resources are maximized. The Department's ability to keep apprised of local conditions and to ensure the stability of the MCH infrastructure is supported the Public Health Law, strong regulations, its data collection and data analysis capacity, technical assistance capacity, and through oversight of contracts and letters of agreements with local providers of service.

Local Health Departments: County health departments continue to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under New York State Public Health Law, the **58 local health departments** extend the powers of the state health commissioner. Each of the non-New York City counties have a county health department, while all five counties in New York City are covered by the New York City Department of Health. The county health departments provide community health assessment, family health services, health education and disease control services. Most also provide environmental services. Counties that do not provide their own environmental services rely on the State Health Department's District Office in their area. Most counties in New York also operate certified home health agencies or licensed home health care agencies, through which they provide a variety of home-based services, including skilled nursing, home health aide, therapies, early intervention, maternal and child health and disease control visits. Most counties also operate diagnostic and treatment centers operated under Article 28 of the New York State Public Health Law. The trend is for counties to either divest personal care services or ensure that they are competitive in the market environment. There is also an emerging trend toward streamlining the administrative structures of local agencies. As a result, a handful of New York's local health agencies have combined with other county agencies, such as mental health or social services.

Under **Article 6** of the Public Health Law, local health departments perform comprehensive community health assessment on a two-year cycle, and subsequently produce a county-wide (or in the case of New York City, a city-wide) Municipal Public Health Service Plan (MPHSP). These local plans explicitly address the needs of the maternal and child health population in sections on health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. The Title V program staff provide technical assistance to local health units in plan development and participated in the review and approval process, as well as in monitoring of the implementation of the plans. Because local health departments know their local systems and community needs, the Plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health departments play a critical role in fostering local collaborations.

Relationships with local health departments are coordinated through the **Office of Local Health Services,** the unit that also administers the local assistance/state aid program. Collaboration between the counties and the State and between agencies on the local level is yielding better use of data, better local plans, and more attention to outcomes of public health activities.

Perinatal Regionalization/Tertiary Care Centers/Regional Perinatal Centers: New York State has a long-established system of regionalized perinatal care with highly specialized **Regional Perinatal Centers (RPCs)** in each region of the state. These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of Health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to monitor perinatal morbidity and mortality and to provide education and technical assistance to physicians and others. The RPCs have helped the Department address important public health issues such as perinatal HIV, breast-feeding promotion, cesarean prevention, and collection and use of perinatal data.

The Department of Health worked collaboratively with hospitals of all levels and stakeholders statewide in perinatal care to re-examine the **perinatal designation levels** of all hospitals that provide obstetrical and newborn care. Factors like managed care, hospital downsizing and hospital mergers have altered the relationships between individual facilities and the Regional Perinatal Centers. New designations were prepared for all obstetrical hospitals based on the level of care available to both high-risk mothers and infants.

The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. The implementation of the Statewide Perinatal Data System (described under Information Infrastructure) has been closely tied to Perinatal Regionalization**.** The Regional Perinatal Centers are key to the development of a system for quality improvement within an affiliate network. SPDS is an important source for data for those activities. The Centers have responsibility for data quality within the network, including responsibility for training and technical assistance to affiliate hospitals. During 2002, Regional Perinatal Centers received their final designations as to level of perinatal care. Workplan guidance was developed and disseminated to all Regional Perinatal Centers in order that they gain a clearer understanding of their roles as leaders in regionalization. Throughout 2003, the Department worked with the Regional Perinatal Centers to enhance their understanding of the provision of quality improvement activities among their affiliate network and promoted their leadership in the Regional Perinatal Forums to work with community collaborators in promoting improved perinatal outcomes within their regions.

Information Infrastructure

The Department of Health continued to improve accessibility of local data, both on the internet-based public website and on our intra-net, the **Health Information Network (HIN).** More and better data became available via electronic means in 1999 and 2000. This application has been posted on our public website since 1997.

Statewide Perinatal Data System: A **Statewide Perinatal Data System** is now implemented in every area of the State except New York City. This system involves the regional centers in coordinating data analysis for their regions and in helping their affiliated hospitals and others in the community (such as perinatal networks) use data for needs assessment, planning and quality improvement activities. It is anticipated that New York City will utilize the Statewide Perinatal Data System in the near future.

The Statewide Perinatal Data System (SPDS) provides a wealth of information on our achievement of our goals. The system is an internet-based, secure network consisting of all data

from the Electronic Birth Certificate and data collected from hospitals and free-standing birth centers within the State as well as additional data elements. The system will be used to assess birth outcomes at three levels: within hospitals, in integrated health care systems and in the community. It will enable the Department to identify, in real-time, health care delivery and public health problems. It will provide a powerful tool for quality assurance and quality improvement. At the same time that electronic birth certificate information is being collected, the system also collects the content of prenatal care, breastfeeding status on discharge from the hospital, maternal depression during pregnancy and periodontal disease during pregnancy. The development of the Statewide Perinatal Data System requires regulatory amendments. New regulations were proposed and are being processed through the Department for adoption.

Indicators of maternal and child health are built into the **Quality Assurance Reporting Requirement (QARR) System** for monitoring managed care and Child Health Plus providers. Title V works closely with the Office of Managed Care to make health plan performance data available to county health departments so that they may monitor the delivery of care to the population within their county.

The **SSDI Project** continued to support the **Children with Special Health Care Needs (CSHCN) Program** by assisting with the development of the data system. The CSHCN data will be linked with other child health data sets via the **Integrated Child Health Information System**. The Project also revised and reprinted the Resource Directory for CSHCN. Over 50,000 directories were distributed to local health departments, hospitals, community-based organizations, schools, libraries, families and other providers. The directory is available in English, Spanish, Russian, Chinese and French.

MCH and Public Health Education Infrastructure

The **New York State Preventive Medicine Residency Program** trains five physicians annually, preparing them for leadership careers in state and local health departments. The program seeks to reduce health disparities among New Yorkers by increasing the number of well-trained public health physicians to address the needs of high-risk populations. This two-year residency program for physicians consists of an academic year, leading to a Masters in Public Health degree, and a practicum year, during which public health residents complete projects throughout the New York State Department of Health and affiliated sites. Many of the residents go on to employment at the New York State Department of Health and other public health agencies in important maternal and child health positions. They include the former director of the Division of Family Health, the director of the Bureau of Child and Adolescent Health, and the medical directors of the Bureau of Women's Health, the Immunization Program and the Hospital Epidemiology Program. The Program was recently awarded a three-year grant from the American Cancer Society, supplementing the support provided by the Maternal and Child Health Services Block Grant.

The **Dental Public Health Residency Program** graduated three residents from its statewide program. The Program continued its accreditation status and continued to collaborate with four dental residency sites in New York State. The Bureau of Dental Health currently employs one Resident, one Senior Resident and one graduate of the residency program.

In 2001, **GENES, the Genetic Network of New York, Puerto Rico and the Virgin Islands,** hosted three general sickle cell committee meetings, a sickle cell symposium, and a conference on the Genetics of Diabetes attracted about 125 medical professionals and consumers. There is renewed interest in resurrecting a GENES format for the region.

The Bureau of Women's Health worked with the **Research, Advocacy, Information Network for the Bodily Integrity of Women (RAINBOW)**, a non-profit organization, to develop and

disseminate professional and community education materials dealing with medical, religious, cultural, and legal issues related to female circumcision. The project raised awareness of female circumcision among New York families and to provided physicians, midwives, nurses, and other health care providers with information about caring for women experiencing short- and long-term consequences of the circumcision. By reducing the practice of female circumcision and ensuring the medical practitioners are aware, children may be spared this traumatic and life-threatening experience, and potentially fatal long-term complications may be averted.

Area Health Education Centers (AHECs): The **State University of New York at Buffalo**, Division of Family Medicine is developing **Area Health Education Centers (AHECs)**. The Centers works to recruit, retain, and support health professionals to practice in communities with health provider shortages. They do so by developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, by providing continuing education and professional support for professionals in these communities and by encouraging local youth to pursue careers in health care. Plans currently call for the establishment of 9 AHEC offices across the State by the year 2010. Sites are currently operational in: Buffalo, Batavia, Potsdam, Glens Falls, Cortland, the Bronx. Two additional sites will be located in the Erie-Niagara and Catskill area, with the exact sites to be determined.

Title V has established a relationship with the AHECs. Dr. Thomas Rosenthal, AHEC Project Director, met with the Maternal and Child Health Services Advisory Council to exchange information and investigate collaboration opportunities. The Advisory Council and the AHECs are mutually concerned about the aging of the health care workforce, the aging of nursing faculty, current shortages in certain key health professions, and in interesting young people in health careers early in their student careers. The Bureau of Dental Health is working with AHECs to improve access to primary dental care, especially in rural areas.

Universities and Schools of Public Health: The **University at Albany School of Public Health** is unique in that it is jointly sponsored by a university and a state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's **Continuing Education Advisory Board**, providing approvals for continuing medical and nursing education. Title V has utilized the School of Public Health as the continuing medical education provider for its annual Breastfeeding Grand Rounds, and for forums on public health genetics, HIV/AIDS, the dental public health residency, home visiting, women's health and female circumcision. Among the other offerings through continuing education are: social marketing, environmental health, Hepatitis C, substance abuse, and occupational health and safety.

Title V staff in the Division of Family Health coordinate the **MCH Graduate Assistant Program**, under which fifteen University at Albany School of Public Health graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright and motivated individuals who are interested in gaining both theoretical and practical knowledge of public health and maternal and child health. The use of students also enhances the Department's research capacity, and improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region.

The University at Albany's School of Public Health sponsors the **Northeast Public Health Leadership Institute**, now serving the northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health.

The Department also maintains a relationship with the **Columbia University School of Public Health** through a **Collaborative Studies Initiative**. Metropolitan Area Regional Office staff serve as advisors to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in designing and implementing solutions to those issues.

University Affiliated Programs: New York is fortunate to be home to three **University-Affiliated Programs** who offer **Leadership Education in Neurodevelopmental Disabilities (LEND)**. The three are located at the **University of Rochester**, the **Westchester Institute at Valhalla**, and **Jacobi/Albert Einstein Medical Center**. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues. For example, the Bureau of Child and Adolescent Health worked with staff at Jacobi/Albert Einstein to improve identification of children with special health care needs. The Department has participated in joint planning with the Westchester Institute, and we are jointly exploring the possibility of a policy internship for LEND faculty at the Department of Health and to have Department of Health staff participate in the LEND training.

Title V and the Adolescent Coordinator maintain linkages to the **Leadership Education in Adolescent Health (LEAH) Program** at the **University of Rochester.** The purpose of LEAH is to prepare trainees in a variety of professional disciplines for leadership roles in the public and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Training is given in the biological, developmental, emotional, social, economic and environmental sciences, within a population-based public health framework. Prevention, coordination and communication are stressed.

Pediatric Pulmonary Center: New York's **Pediatric Pulmonary Center** is located at **Mount Sinai Medical Center** in Manhattan. The Pediatric Pulmonary Center takes an interdisciplinary approach to developing health professionals for leadership roles in the development, enhancement or improvement of community-based care for children with chronic respiratory diseases and their families. In addition serving as a model of excellence in interdisciplinary training, Mount Sinai also engages in active partnership with state and local health agencies and provides model services and research related to chronic respiratory conditions in infants and children. The Department is working with a pediatric pulmologist from Mount Sinai on a school-based asthma management initiative. Mount Sinai is a CDC National Cooperative Inner-City Asthma Study grantee, as are Albert Einstein College of Medicine and Bronx-Lebanon Hospital in the Bronx and University of Buffalo.

Behavioral Pediatric Training Center: Montefiore Medical Center sponsors the **Behavioral Pediatrics Training Program**. Training grants from the Federal Maternal and Child Health Bureau support faculty who demonstrate leadership and expertise in the teaching of behavioral pediatrics, scholarship and community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fellowship program includes course work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and health promotion. The program is also available to provide continuing education and technical assistance.

Montefiore was also the sponsor of the **Prenatal Education and Awareness of Safety (PEAS Project),** through its Family Health Center. The PEAS Project implemented a model domestic violence protocol for recognition and intervention with clients who are abused. The model

consists of professional education, the addition of an on-site domestic violence coordinator, a public health campaign for patient and community education, the use of a standardized tool as an avenue for disclosing abuse, and systems changes that support the change in practice (chart prompts, documentation forms, inclusion in quality assurance). Their focus is on prenatal patients, but the principles and procedures are applicable to all women and men who are abused.

Statewide Satellite Broadcasts: The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly **Third Thursday Breakfast Broadcasts (T2B2).** T2B2 provides continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available. Series have focused on Children's Health, Quality of Life, Emergency Preparedness, Promoting Healthy Behavior, and Model Programs.

The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

Infrastructure for Collaboration

The Department of Health continued to support a variety of **regional and local collaborative** to improve needs assessment, identify and build local capacity, outreach to hard-to-reach segments of the population, and assure quality. The common thread among these efforts is community engagement and commitment to collaboration and coordination in the use of resources. Examples of such efforts include: Comprehensive Prenatal Perinatal Services Networks, Rural Health Networks, community assessment and joint planning initiatives, Comprehensive Planning for Youth Services, Partners for Children, Early Intervention Coordinating Councils, the affiliation networks of the regional perinatal centers, regional EMS councils, Infant Mortality Review Community Councils, HIV/AIDS Prevention Planning Groups, and many more.

Voluntary and Professional Organizations: DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has active relationships/collaborations with:

- Family Voices;
- Family Support New York;
- New York State Alliance for Family Literacy;
- Parent-to-Parent, New York State;
- New York State Public Health Association;
- Healthy Start;
- New York State Perinatal Association;
- New York State Association of County Health Officials;
- New York State Association of Counties;
- New York State Nurses Association;
- March of Dimes;
- New York State United Teachers;
- Boards of Cooperative Education Services (BOCES);
- New York State School Boards Association;
- New York State Child Care Coordinating Council;
- New York State Partners for Children;

- The New York State Council on Sexual Assault;
- New York State Community Health Partnership;
- University Affiliated Programs at Westchester, Rochester and Jacobi/Albert Einstein;
- American Academy of Pediatrics, District 2;
- New York Academy of Medicine;
- American College of Obstetricians and Gynecologists, New York State Chapter;
- American Academy of Family Practice, New York State Chapter;
- American College of Nurse Midwives, New York State Chapter;
- New York State Association of Perinatal Programs;
- Medical Society of the State of New York;
- Healthcare Association of New York State (representing hospitals across the state);
- Greater New York Hospital Association (representing hospitals in the Greater Metropolitan area);
- Schuyler Center for Analysis and Advocacy, formerly the State Communities Aid Association;
- Cornell University Cooperative Extension, Human Development Center and 4-H;
- YMCA of New York State
- United Way of New York State;
- Association of New York State Youth Bureaus;
- New York State School Boards Association;
- School Nurses statewide;
- University at Albany School of Public Health;
- Columbia University School of Public Health;
- University at Buffalo School of Social Work;
- Leadership Education in Adolescent Health at University of Rochester;
- Mount Sinai Adolescent Center;
- SIDS Alliance;

and many others who enhance the capacity of Title V programs to operate effectively.

5. Selection of State Priority Needs

The overall goals for health care delivery in New York are:

- to continue insurance coverage and enrollement of the uninsured and underinsured;
- to assure that the health care delivered in New York State is of high quality;
- to emphasize prevention and education by involving communities in addressing and improving health; and
- to create a seamless health care system whereby our residents may retain continuous health care delivery at a "medical home" irrespective of insurance status.

In addition, Governor Pataki has set these more specific goals for health in New York:

- to reduce potentially deadly asthma attacks in children;
- to ensure that every child in New York receives all their vaccinations by their second birthday;
- to ensure that every newborn is screened for hearing impairment;
- to significantly reduce smoking among youth in New York State; and
- to protect infants born to HIV-infected mothers to ensure that virtually none develop AIDS.

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine.

As previously described, New York has undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

Most often, programs that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

The following are New York's maternal and child health services priority needs:

- To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care which includes attention to mental health issues and which serves those with special health care needs;
- To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- To prevent and reduce the incidence of overweight for infants, children and adolescents;
- To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;

- To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
- To reduce unintended and adolescent pregnancies;
- To implement new genetics tests within the statewide system of newborn metabolic screening;
- To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
- To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

The Maternal and Child Health Services Block Grant Advisory Council elaborated on these needs:

- Relative to access to care, the Advisory Council reinforced that all children and adolescents need access to comprehensive primary and preventive services that is consistent with the Child-Teen Health Plan (EPSDT) and includes a specific source for ongoing primary care or a "medical home" and a specific source for ongoing dental care.

- Dental services for children should include fluoridation or fluoride treatment and dental sealants.

- Children with special health care needs should also have access to a source on care that prevents secondary disability and improves or maintains their quality of life. This includes access to evaluation and treatment sources for CSHCN, access to early developmental and hearing screening, access to early intervention services, early coordination of their care and family support services, and access to clinical and laboratory genetics services.

- Relative to pregnant women, the MCHSBG Advisory Council stressed the need for comprehensive and effective prenatal care. This should include health education on pregnancy and child care, outreach and home visitation, nutritional counseling, prevention of tobacco, drug, alcohol and substance abuse, HIV prevention services, prevention of congenital infection, and detection or prevention of genetic disorders.

- On the subject of education, the MCHSBG Advisory Council stressed the need for comprehensive health education, beginning at an early age, and including HIV prevention, substance abuse, family life, sexuality, conflict resolution skill building, and healthy lifestyles.

- Mental health issues and issues related to violence clearly have an impact on the health status of the maternal and child population. The Advisory Council sees the need for suicide prevention and post-partum depression services in each community.

- Further, violence related to homicide, child abuse and neglect, other domestic violence and assault are clearly issues. The Advisory Council stressed the need for families to provide nurturing care to their children.

- The Advisory Council continually re-affirms the value of parent and consumer input in their decision-making process.

Priority needs relate to all MCH population groups and all levels of the MCH Pyramid.

C. Needs Assessment Summary

As a result of New York Title V needs assessment process, the following ten priorities have been identified:

1. To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs;
2. To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
3. To prevent and reduce the incidence of overweight for infants, children and adolescents;
4. To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
5. To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
6. To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
7. To reduce unintended and adolescent pregnancies;
8. To implement new genetics tests within the statewide system of newborn metabolic screening;
9. To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
10. To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

The justification for their selection as priorities may be found in Section II. B.1. and a description of our planning/targeting framework may be found in Section II.A.

Priority setting was conducted as a melding process, combining:

- The results community-participative processes;

- The use of the many and various data sets available to the Department, such as:
    - Routine surveillance of vital statistics/vital records;
    - Census data;
    - Registries;
    - Hospital discharge data;
    - Special studies;
    - Community-based assessment data;

- The use of program data and provider input to identify trends and issues;

- Infrastructure evaluation;

- The input of the public and the Maternal and Child Health Services Advisory Council, including the input of those who spoke at focus groups, the public hearings or sent testimony, to assist in interpreting data and identifying important trends, gaps in services or barriers to care; and

- The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process have also remained unchanged. NYSDOH will continue to strive to meet these needs.

D. Health Status Indicators

Please see Form 20 and 21 for multi-year reports on required Health Status Indicators. Below, please see brief explanations of program efforts designed to address the indicators.

#01A Health Status Indicator
The percent of live births weighing less than 2,500 grams.

Please see graphs and discussion of low birthweight and very low birthweight data on pages 47 through 49, figures 12 through 17, and table 7.

These data are affected by multiple births and the growth of assistive reproductive technology. Assisted reproduction and infertility treatments are associated with an increase in multiple and pre-term births.

The availability of comprehensive prenatal care to all women through the PCAP and MOMS Programs will result in healthier births.

In 2004, 89.1% of infants born to women in the Community Health Worker Program were of normal birthweight, 8.8% were low birthweight, and 1.9% were very low birthweight. There were no data on 0.2% of births. Fully 5.0% of the low birthweight births were the result of multiple births.

Through preconception and prenatal genetic counseling and screening, babies who may be at risk for genetic, infectious or other congenital conditions can be identified before birth. The mother is offered appropriate options, including close monitoring of fetal development throughout the pregnancy, fetal surgery or other medical interventions, deliver in tertiary medical facilities with neonatal intensive care units, early developmental assessments and interventions, and termination of pregnancy.

#01B Health Status Indicator
The percent of live singleton births weighing less than 2,500 grams.
#02A Health Status Indicator
The percent of live births weighing less than 1,500 grams.
#02B Health Status Indicator
The percent of live singleton births weighing less than 1,500 grams.

For discussion and trend information on these indicators, please refer to pages 47 through 49 of this Needs Assessment and program efforts briefly described above.

#03A Health Status Indicator
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

- Bureau of Injury Control sponsors multiple programs in pedestrian and passenger safety, head injury prevention, burn prevention, and child safety.
- Bureau of Injury Control is represented at meetings of the Governor's Traffic Safety Committee.

- In 2004, reports for 958 camper injuries and 13 staff injuries were collected and entered into the injury surveillance database.
- In 2004, 25 local health departments were audited for permit issuance, inspections, written safety plan, and injury reporting and investigation requirements. As a result of this analysis, the State Sanitary Code was amended to require bunk bed guardrail installation.
- In 2004, statewide inspector training programs were conducted in the spring and faill, training a total of 478 inspectors in camp safety and regulations.
- Written information regarding injury prevention was sent to all local health departments.
- Safety information was presented to camp operators at the American Camping Association Upstate Camp Conference.
- In 2004, 17 allegations of abuse with a total of 20 victims were reported, investigated and entered into the incident surveillance system. Prevention strategies and findings from these incidents were shared in trainings and through mailings.
- In 2004, 484 incidents of illness, 140 bat exposures and 12 epinephrine administrations were reported by camps and entered into the illness surveillance system. 27 outbreaks were also reported and investigated. Data from analysis of illness due to potable water supplies was used to justify amendment of the State Sanitary Code to require additional disinfection, start-up procedures and sampling requirements.
- The Public Health Law and the State Sanitary Code now require additional immunizations be completed.
- No campers drowned in the 2004 season.
- Children's Camp regulations were amended relative to on-site, off-site and wilderness swimming and incidental water immersion to better protect against drowning.

#03B Health Status Indicator
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. – and –
#03C Health Status Indicator
The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.
#04B Health Status Indicator
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
#04C Health Status Indicator
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

See pages 66 and 67 of this Needs Assessment.

New York's rate of motor vehicle crashes are at an all-time low. This phenomenon was recently studied at the direction of HRSA by the University of North Carolina at Chapel Hill's School of Public Health.

The low rates are attributed to:
- a long history of stakeholder collaboration around traffic safety and the positioning of the Traffic Safety Commission, which reports directly to the Governor;
- highway engineering that provides wide shoulders on roads, good visibility, rumble strips, easily accessible and sensibly spaced rest areas, and clear, well-placed directional signs;
- STOP DWI efforts, and efforts of private groups such as Mothers Against Drunk Driving and RID, which advocates for removing intoxicated drivers from the roadways;
- excellent enforcement; and
- stringent driving regulations.

The lead within NYSDOH for traffic related public health issues is the director of the Injury Control Program. See information above on program efforts of the Bureau of Injury Control.

#04A Health Status Indicator
The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

- Please see information above on the Bureau of Injury Control.
- 56 Bushwick families enrolled in the Healthy Families New York Program (Bushwick Bright Start) received home safety assessments, education and remediation plans and services. All families received fire extinguishers, carbon monoxide detectors, and first aid kits. All family services workers in the program were trained in home safety and scored 95% or higher on post-training assessment.
- Comprehensive Prenatal/Perinatal Service Networks sponsor educational offerings, some of which focus on domestic violence and child safety.

#05A Health Status Indicator
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
#05B Health Status Indicator
The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Please see discussion and data display on pages 65 and 66 of this Needs Assessment. Chlamydia rates are rising, but it is impossible to assess how much of the increase in cases is due to increased awareness, testing and case ascertainment.

#06A and B, 07 A and B, 08 A and B, 09 A and B, 10, 11 and 12 Health Status Indicators
Demographics - Please see Form 21.

E. Outcome Measures – Federal and State

Outcome measures denote the final desired result of Title V program activities and interventions. Progress on outcome measures can be attributed to any number of program activities and influences from the health care and social environments. Effectively reducing adverse events requires programmatic investment across the various levels of the MCH Pyramid and the various MCH populations.

Please refer to Form 12, which tracks New York's progress on the six required outcome measures. Outcome measures are indicative of the collective efforts of New York's public and private health care systems to obtain optimum health for all New Yorkers. Local health departments, who monitor health outcomes through statutorily required community health assessments, may use local funds and State Aid to Localities to pay for tracking of outcomes in their municipality. However, Title V funding supports training and technical assistance, data production and posting of information on Department of Health websites on the Internet and the intranets.

Relative to our State Outcome Measure, maternal mortality, all of the Department's maternal and child health programs, but especially the Prenatal Care Assistance Program (PCAP), MOMS, Medicaid and Managed Care, promoted early entry into prenatal care, provision of related

services, coordination of care through the intrapartum and postpartum periods, risk assessment and provision of risk-appropriate care. PCAP Part 85.40 standards apply to all pregnancy-related care under Medicaid and Managed Care.

The table below indicates how New York State MCH priorities relate to Federal and State Outcome Measures.

Priority Area	**Applicable Outcome Measure**
Access to Care	1 – 6, NY
Oral Health	1
Disparities, especially LBW and IM	1 – 6, NY
Asthma Hospitalizations	6
Reducing Use of Tobacco among Students	1, 2, 3, 5
Reducing Use of Alcohol among Students	6
Responsible Sexual Activity	---
Lead Screening	6
Self-Inflicted Injury	6
Parent Partnership	---

The matrix on the next page gives examples of how the various programs relate to the various Federal and State Performance and Outcome measures. On the page after that appears the model for NYS Title V performance evaluation.

Relationship of Measures to Program Activities: In New York State, multiple programs contribute to multiple outcomes. The following matrix cross-references programs with the National Performance Measures, National Outcome Measures and State-Selected Performance Outcome Measures. Each performance measure or outcome is only counted once below, though the measure or outcome may be related to more than one level of the pyramid.

NYS MCH Programs	*National Performance Measures*																		*National Outcome Measures*						*State Selected Performance Measures*									*State Outcome Measure*
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*1*	*2*	*3*	*4*	*5*	*6*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	
Abstinence Education						★		★							★				★	★	★	★	★	★	★			★							★
ACT for Youth/ Youth Development			★			★		★								★								★	★		★			★	★	★	★		
American Indian Health Program	★	★	★	★	★	★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Asthma/ Asthma Coalitions		★	★		★																					★									
Childhood Injury Prevention										★						★			★					★							★	★			
CSHCN Program		★	★	★		★						★	★	★					★					★		★									
Chlamydia/STD								★																											
Columbia Collaborative		★																								★									
Communities Working Together	★	★	★	★	★	★	★	★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Comm-based Adoles. Preg. Prev.						★		★							★				★	★	★	★	★	★	★			★							★
Community Health Worker		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Congenital Anomolies Registry																			★	★	★	★	★	★											
Dental Public Health Residency									★				★	★																					
Dental Preventive Programs		★		★	★				★				★	★																					
Early Intervention	★	★	★	★	★					★		★	★	★					★					★										★	
Eat Well, Play Hard																													★						
Family Planning				★	★	★		★					★	★	★	★		★	★	★	★	★	★	★	★		★	★	★		★	★	★		★
Genetics Services/ Newborn Screening	★	★	★	★	★	★						★	★	★				★	★	★	★	★	★	★											★
HIV-Related Services	★	★	★	★	★	★		★					★	★	★	★		★	★					★											
Hotlines and CPPSN	★		★	★	★	★	★	★			★		★	★	★	★		★	★	★	★	★	★	★	★	★	★	★	★		★			★	★
Immunization & Hep B Follow-up		★	★	★	★	★	★						★	★			★																		
Infant /Child Mortal Review/ SIDS															★	★	★	★	★	★	★	★	★	★	★	★	★	★		★	★	★			
Lactation Institute/ Breastfeeding Prom		★								★	★																		★						
Lead Poisoning Prevention & Fllwup		★	★	★	★								★	★										★										★	
Medicaid/Uninsured Projects/CHP	★	★	★	★	★	★	★	★				★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★		★	★	★	★	★
Migrant Health	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Pediatric Enhanced Services		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Pren. Care Assist. Prog. (PCAP)		★	★	★	★	★	★	★		★		★	★	★	★	★	★	★	★	★	★	★	★		★		★	★	★	★		★	★		★
School Health		★	★	★	★	★	★	★	★	★			★	★	★	★		★						★	★	★	★	★	★	★	★	★	★	★	★
Tobacco Control Activities						★									★											★	★						★		

NYS - TITLE V PERFORMANCE MEASUREMENT SYSTEM

Needs Assessment → *Select Priority Needs* → *Program Implementation* → *Performance Measurement National and State Perf. Meas.* → *Improved Health Outcomes* → Start Again

Tracking Data/Trends Analysis:

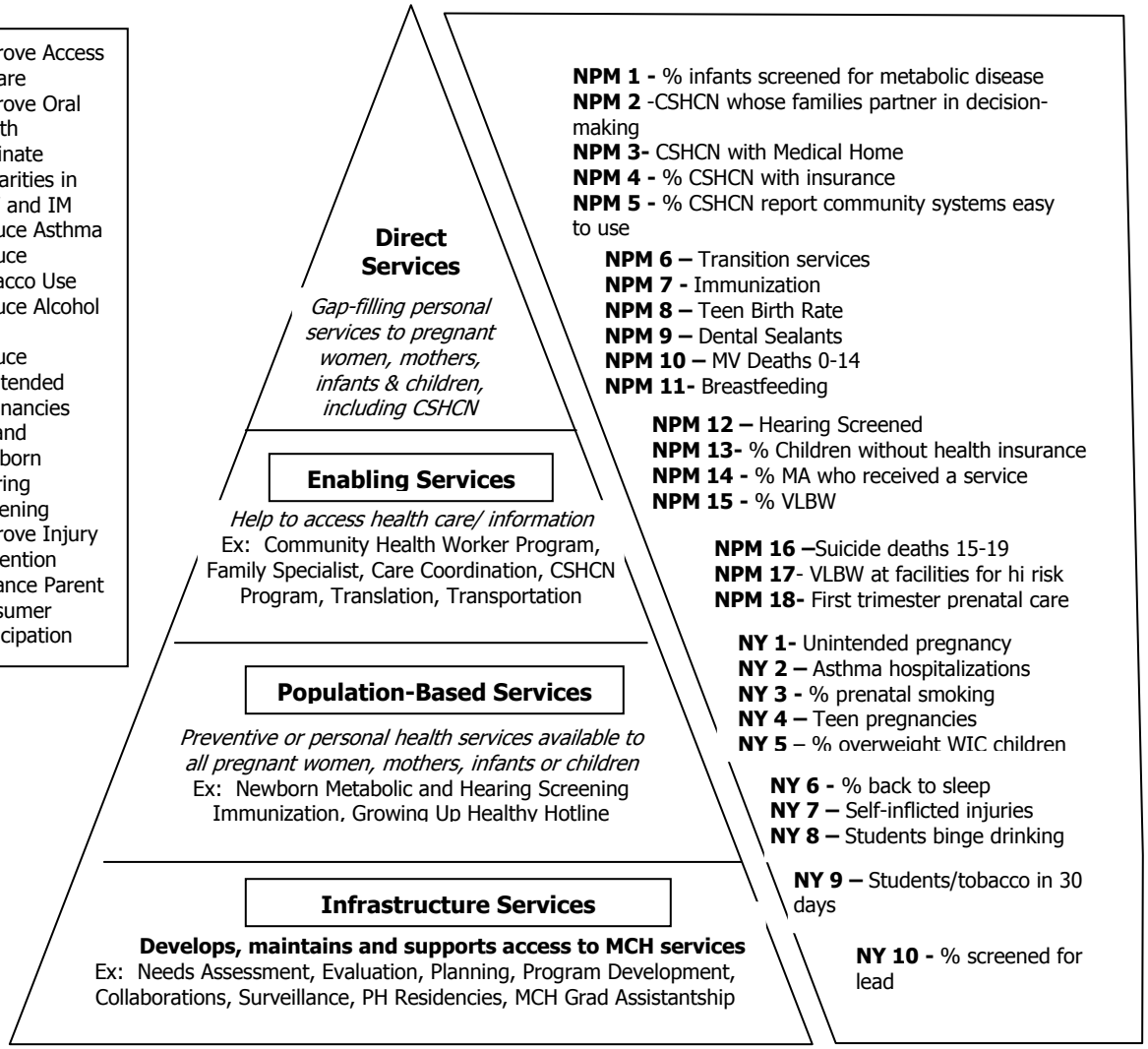
- Vital Records
- Census Data
- Registries
- Hospital Discharges
- Program Data/Payer Information
- Special Studies
- Community Assmnt.
- Health Status Indicators
- Infrastructure Evaluation

Input from Parents and Consumers

Input from Advisory Council

Input of Key Staff

1. Improve Access to Care
2. Improve Oral Health
3. Eliminate Disparities in LBW and IM
4. Reduce Asthma
5. Reduce Tobacco Use
6. Reduce Alcohol Use
7. Reduce Unintended Pregnancies
8. Expand Newborn Hearing Screening
9. Improve Injury Prevention
10. Enhance Parent Consumer Participation



NPM 1 - % infants screened for metabolic disease
NPM 2 -CSHCN whose families partner in decision-making
NPM 3- CSHCN with Medical Home
NPM 4 - % CSHCN with insurance
NPM 5 - % CSHCN report community systems easy to use
NPM 6 – Transition services
NPM 7 - Immunization
NPM 8 – Teen Birth Rate
NPM 9 – Dental Sealants
NPM 10 – MV Deaths 0-14
NPM 11- Breastfeeding
NPM 12 – Hearing Screened
NPM 13- % Children without health insurance
NPM 14 - % MA who received a service
NPM 15 - % VLBW
NPM 16 –Suicide deaths 15-19
NPM 17- VLBW at facilities for hi risk
NPM 18- First trimester prenatal care

NY 1- Unintended pregnancy
NY 2 – Asthma hospitalizations
NY 3 - % prenatal smoking
NY 4 – Teen pregnancies
NY 5 – % overweight WIC children
NY 6 - % back to sleep
NY 7 – Self-inflicted injuries
NY 8 – Students binge drinking
NY 9 – Students/tobacco in 30 days
NY 10 - % screened for lead

OM 1 – Infant Mortality

OM 2 – Ratio BIM to WIM

OM 3 – Neonatal Mortality

OM 4 – Post-Neonatal Mortality

OM 5 – Perinatal Mortality Rate

OM 6 – Child Death Rate

NY OM – Maternal Mortality